

NORTH STATE COUNSELING

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Consent to Treat a Minor

Client Name: _____ DOB: _____

Parents are: Married Divorced Separated Living together/unmarried Never Married/not living together

If child's parents are divorced, separated, or never married/not living together, please provide a copy of the current custody order to determine who is legally required to consent to treatment. Alternatively, if both parents consent to treatment, both can sign below. If no court order is available, please complete the explanation section below.

Children 12 years of age and above can give consent to their own mental health care, if the mental health professional deems them mature enough to intelligently participate in treatment. However, we strongly encouraged the adolescent to obtain parental consent.

Important Information:

Therapy is most effective when a trusting relationship exists between the therapist and the child. Privacy is especially important in securing and maintaining that trust. It is necessary for children to establish a "zone of privacy" with their therapist that allows them to feel free to discuss personal matters. Therefore, it is my policy to provide you with general information about the treatment of your child, but I will not share with you what your child has disclosed to me without your child's consent. However, if I ever believe that your child has been abused or is at serious risk of harming him/herself or another, I will inform you. This "zone of privacy" extends to information contained in treatment records as well. By signing this agreement, you are waiving your right of access to your child's treatment records. I will be happy to provide a written treatment summary upon request. I will also inform you if your child does not attend sessions or if it is necessary to refer your child to another mental health professional.

Adolescence is a time when children need to develop a greater sense of independence and autonomy. If your child is an adolescent, it is possible that he/she will reveal sensitive information during therapy sessions regarding sexual contact, alcohol and/or drug use, or other potentially problematic behaviors. In order for me to effectively work with your child, it is necessary for me to maintain confidentiality about these behaviors unless they involve imminent risk of harm to self or others, such as driving while under the influence of alcohol or drugs.

If either parent decides that therapy should end, I ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship and to provide appropriate referrals as necessary.

If conflicts arise between parents, you understand and agree that my role is strictly limited to providing psychotherapy for the benefit of your child. This means, among other things, that you will treat anything said in session as confidential and you will not attempt to gain advantage in any legal proceeding from my involvement with your child. You agree that you will not involve me in any legal dispute, especially a dispute concerning custody or visitation arrangements. You will not ask me to testify in court, either in person or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

If a court appoints an evaluator, mediator, or guardian ad litem, I will provide information as needed, if appropriate releases are signed or a court order is provided. I am ethically bound not to give my opinion about either parent's

custody or visitation suitability. If, for any reason, I am required to participate in a legal dispute, the party responsible for my participation agrees to reimburse me at the rate of \$120/hour for time spent testifying, being in attendance at hearings, or any case-related costs. Additional fees will be incurred for preparing reports, telephoning, and travel time.

Thank you for your understanding and cooperation. If you have any questions about the information contained in this contract/consent, please discuss them with me prior to signing below. Your signature indicates legally-binding agreement with the terms set forth in this contract/consent.

Parent Name: _____ **Phone #** _____

Address: _____

Signature: _____ **Date:** _____

Parent Name: _____ **Phone #** _____

Address: _____

Signature: _____ **Date:** _____

Child 12 years old or older consenting to own treatment:

Signature: _____ **Date:** _____

Therapist: _____ **Date:** _____

Comment Section:
