Treatment Consent for Minor

Addendum to Treatment Consent

Child's Name: ____ Date of Birth: _____/_____/_____

BIOLOGICAL PARENTS OF MINOR CHILD LEGALLY MARRIED TO ONE ANOTHER AND CONSENT TO TREATMENT

If your child is under eighteen years of age, please be aware that the law may provide you the right to examine your child's treatment records. When I treat children under the age of 12, it is my policy to share all clinical information with the parents or legal guardians. For clients between the ages of 12 and 18, It is my policy, with your signed consent, to only provide general information about our individual work together, unless your child is suicidal or homicidal or engaging in "high risk" behaviors that may cause harm. In these instances, I will immediately notify you of my concern.

We, affirm that we have the legal authority to seek and grant permission for therapeutic treatment for the above-mentioned minor child(ren).

(Mother's Signature) ____ Date:________________

(Father's Signature) ____ Date:_________________

BIOLOGICAL PARENTS OF MINOR CHILD LEGALLY DIVORCED THE CUSTODIAL PARENT'S CONSENT TO TREATMENT. (*That is by legal decree, you have the SOLE right to seek and consent to therapeutic treatment for the above-mentioned minor child(ren).*

I, affirm that I am the custodial parent / managing conservator and have the sole authority to seek and grant permission for therapeutic treatment for the above-mentioned minor child(ren). There being no legal decree or modification disallowing my authority to assume such responsibility.

(Custodial Parent Signature) ____ Date:_________________

CONFIDENTIALITY WAIVER FOR ADOLESCENTS BETWEEN THE AGES OF 12-18

Privacy in psychotherapy is often crucial to successful progress and outcomes, particularly with adolescents. Therefore, it is my policy to request an agreement from parents / legal guardians to waive their right to obtain information from records from A.M.A. Counseling Services, LLC pertaining to the evaluation and treatment of the above-mentioned minor children between the ages of 12-18. I will however provide you with general information about your teen's progress, treatment, and his / her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete with a written request to do so. Any other communication will require the adolescent's authorization, unless I feel that he / she is in danger of harming self or others or is actively engaging in high-risk behaviors, in which case I will immediately notify the parents of my concern. I will always discuss the matter with the adolescent first and do my best to handle any objections he / she may have.

I hereby waive my right as parent / guardian to obtain information from and copies of any records from A.M.A. Counseling Services, LLC pertaining to the evaluation and treatment of the following child:____________________, age _________.

I understand that A.M.A. Counseling Services, LLC may refuse to provide me, or any third party acting upon my request or authorization, with information and records pertaining to this child's mental health evaluation and treatment, if disclosure in the opinion of the child's therapist would negatively impact the child's evaluation and treatment. I hereby release A.M.A. Counseling Services, LLC.

(Mother's Signature) ____ Date:_________________

(Father's Signature) ____ Date:_________________

(Clinician's Signature) ____ Date:_________________