



Consent for Treatment of Minors

Name of Minor: _____

Date of Birth: _____

Name(s) of Parent/Legal Guardian: _____

This is to certify that I give permission for the therapist signing below to provide psychotherapy, and/or refer my child for further treatment. I understand that this consent will be valid for the duration of the treatment and that I am responsible to inform the provider of any changes in the custody of my child.

I understand that although a parent or legal guardian consents to treatment and may be financially responsible, the minor client maintains the right to confidentiality. Parents or legal guardians may be provided with updates about treatment progress as requested, however the specific content of the minor's meeting with a therapist will not be discussed without the minor's permission. Exceptions to confidentiality include mandated reports regarding abuse situations, disclosure to prevent client from doing serious harm to self or others, or when the minor client gives written permission to disclose confidential information.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I fail to do this, I will be charged for that appointment.

I am aware that if my insurance is being billed for these services, an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that I am responsible for notifying the therapist of any changes to my insurance. I also understand that I am responsible to pay for services I have received if my insurance company denies the claim.

I have agreed to the following financial arrangement with the therapist: (initial correct line)

_____ I have verified coverage and authorization for psychotherapy and want to bill insurance

_____ I will pay \$_____ per 50 minute session (due at time of session)

Signature of Parent/Guardian Date

Signature of Parent/Guardian Date

Signature of Minor Date

Signature of Clinician Date