Consent to Treatment, Ages 11 and Younger

I acknowledge that I have discussed and understand about the therapy or testing I am considering for my child. I have had all my questions answered fully.

I attest that I have legal custody of this child and am able to consent to his/her mental health treatment. I hereby consent that my child may take part in the treatment by the clinician named below. I understand that developing a treatment plan with this clinician and regularly reviewing our work toward meeting the treatment goals are in my child's best interest. I agree to play an active role in this process. I agree to attend sessions on a consistent basis. I understand that services may be discontinued if I consistently miss therapy sessions (i.e.missing 50% of scheduled sessions or missing 3 sessions in a row).

I understand that there may be occasions when my child's therapist or staff may need to physically touch my child for their safety or the safety of others (intervene in the event a child becomes combative or tries to run out of the building).

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this psychologist. I am aware that I may stop my child's treatment with this clinician at any time. The only thing I will still be responsible for is paying for the services we have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment, or pay the agreed-upon $150 fee.

I am aware that 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 my child receives. I understand that if payment for the services I receive here is not made, the clinician may stop my treatment.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

☐_____Date_____

Patient or Guardian Signature