Parent Authorization, Agreement and Consent for Treatment of Child

As a Counseling Clinic our responsibility and goal is the wellbeing of our identified clients and patients. In the case of a child as the primary client, it is essential that parents and/or guardians are in agreement as to the decision to treat, the treatment goals, appointment times and the need to maintain client confidentiality.

As a result, it is our policy of our clinic (herein referred to as “The Clinic”) that all minors presented for treatment have the following authorization and consent of file.

Please check box most appropriate:

☐ **Both legal Parents/Guardians Consent to Treatment (Page 3)**

- Both legal parents/guardians agree to the treatment and proving of mental health services for their child and will indicate their consent below.
- If the biological or legally adopted parents are currently separated or going through the divorce process, both parents are still required to sign a Consent for Mental Heath Treatment Form before the child can be treated.

☐ **Divorce, Custody or Legal Issues (Page 4)**

- There is an official certification decree or legal custody order that indicated that only one parent is legally permitted to determine and decide on mental health treatment of the child without the consent of the other parent (In this case, please provide us with a certified copy of this legal document in its entirety).

☐ **Missing or Deceased Parent (Page 5)**

- The parent presenting child for treatment has no access to other [parent due to the following reasons (death, in prison, missing, has left and made no contact) and therefore will acknowledge that they are the sole primary care taker of the child for mental health treatment and will bare all responsibility for such consent.

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The therapeutic process is a team approach, especially in the case of a minor child, The following informed consent states that each parent, and/or and legal guardian with authority over the health care decision of the child, will agree to these terms and communicate effectively with each other as well as the providers involved to create a supportive and conductive environment for treatment.

Although our responsibility to your child may require our involvement in conflicts between parents and guardians, we need your agreement that our involvement will be strictly limited that that which will benefit your child. This means that you each agree to the following conditions in treating your child:

- You realize limits of confidentiality. That although we maintain full confidentiality of your reports and records with our providers and office staff, we cannot enforce confidentiality among family members, parents, siblings, and/or spouses. We do, however, ask that each party respect the confidentiality of each family member.
- Our role is limited to providing treatment and you shall not attempt to gain advantage in any legal proceeding relating to the care and custody of your child from our treatment of your child;
- You shall not request or require us, through subpoena, summons or other means (except as otherwise ordered by a court of competent jurisdiction), to provide testimony in favor of one parent or guardian against the other in any legal proceeding relating to the care and custody of your child;
- If there is a court appointed evaluator, and if appropriate authorization forms are signed, or a court ordered authorizing disclosure of treatment records is sent to us, we will discuss the requested treatment and general information about the minor but **we will not** make recommendation concerning the child's custody or custody arrangements, unless otherwise ordered by a court.

Client Initials: ______________ Counselor's Initials: ______________

Parent Authorization, Agreement and Consent for Treatment of Child

Both Legal Parents/Guardians Consent to Treatment

Legal Parent 1:

I, ___________________________________, ___________________________________ of

(Parent/Legal Guardian Name) (relationship to child)

_____________________________________, hereby authorize, with the total understanding of the above-mentioned terms and conditions, my child(ern) to receive mental health treatment at Northshore Counseling and Wellness and assume all financial responsibility for their treatment.

I affirm that I have the authority to make health care decisions for my child(ern) and am aware that all custodial parents and legal guardians must give consent before treatment begins.

I understand and agree any breach of these agreements may result in the termination of any, and all, of my (or my child(ern)'s relationship(s) with Northshore Counseling and Wellness or any of its providers, affiliates, and/or staff members. I have been giving the opportunity to ask any questions I may have had and am voluntarily signing this agreement.

Name of Parent: ___________________________________

Signature: ____ Date: ____/____/____

Legal Parent 2:

I, ___________________________________, ___________________________________ of

(Parent/Legal Guardian Name) (relationship to child)

_____________________________________, hereby authorize, with the total understanding of the above-mentioned terms and conditions, my child(ern) to receive mental health treatment at Northshore Counseling and Wellness and assume all financial responsibility for their treatment.

I affirm that I have the authority to make health care decisions for my child(ern) and am aware that all custodial parents and legal guardians must give consent before treatment begins.

I understand and agree any breach of these agreements may result in the termination of any, and all, of my (or my child(ern)'s relationship(s) with Northshore Counseling and Wellness or any of its providers, affiliates, and/or staff members. I have been giving the opportunity to ask any questions I may have had and am voluntarily signing this agreement.

Name of Parent: ___________________________________

Signature: ____ Date: ____/____/____

Parent Authorization, Agreement and Consent for Treatment of Child

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Divorce, Custody or Legal Issues

I, ___________________________________, ___________________________________ of
(Parent/Legal Guardian Name) (relationship to child)
_____________________________________, hereby acknowledge that with the total understanding if the above-mentioned conditions and terms of agreement I authorized my child(ern) to receive mental health treatment at Northshore Counseling and Wellness and assume all financial responsibility for their treatment.

I affirm that I have the authority to make health care decisions for my child(ern) and am aware that all custodial parents and legal guardians must give consent before treatment begins.

I have provided the clinic with a certified or legal copy of the divorce or custody decree that indicated that I have full authority to make any and all decisions regarding my child's mental health treatment.

I further acknowledge and agree that it is ultimately my responsibility to make sure that I am following all legal conditions set fourth by my divorce decree, separation agreements, or other legally binding documents. I acknowledge that Northshore Counseling and Wellness is requesting any and all related documents for the benefit of my child and therefore release any liability to Northshore Counseling and Wellness, any of its providers, office staff, and/or affiliated resulting from a dispute to this authorization.

I understand and agree any breach of these agreements may result in the termination of any, and all, of my (or my child(ern)'s relationship(s) with Northshore Counseling and Wellness or any of its providers, affiliates, and/or staff members. I have been giving the opportunity to ask any questions I may have had and am voluntarily signing this agreement.

Name of Parent: ___________________________________

Signature: ____ Date: ____/____/____

Parent Authorization, Agreement and Consent for Treatment of Child

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Missing or Deceased Parent

I, __________________________________, __________________________________ of

(Parent/Legal Guardian Name) (relationship to child)

____________________________________, herby authorize, with the total understanding of the above-mentioned terms and conditions, my child(ern) to receive mental health treatment at Northshore Counseling and Wellness and assume all financial responsibility for their treatment.

I affirm that I have the authority to make health care decisions for my child(ern) and am aware that all custodial parents and legal guardians must give consent before treatment begins.

I hereby swear and affirm under any applicable perjury laws that there is no legal divorce, custody order, or separation agreement that restricts or limits me from making any or all decisions regarding my child's mental health treatment. I further acknowledge that Northshore Counseling and Wellness has asked and attempted to collect any and all such documents from me.

I further acknowledge and agree that it is ultimately my responsibility to make sure that I am following all legal conditions set forth by my divorce decree and separation agreements, and I acknowledge that Northshore Counseling and Wellness is requesting any and all related documents for the benefit of my child and therefore release any liability to Northshore Counseling and Wellness, any of its providers, office staff, and/or affiliated resulting from a dispute to this authorization.

I understand and agree any breach of these agreements may result in the termination of any, and all, of my (or my child(ern)'s relationship(s) with Northshore Counseling and Wellness or any of its providers, affiliates, and/or staff members. I have been giving the opportunity to ask any questions I may have had and am voluntarily signing this agreement.

Name of Parent: __________________________________

Signature: _______________________________________ Date: ____/____/____