Bridge Counseling Group

Consent to treat Minor Client

This agreement has been written to acquaint you, the minor's parent/guardian, with the basic terms and conditions that promote a successful therapy experience for the minor client. Please read it carefully and do not hesitate to ask any questions.

Any information that you or the minor client shares with me will be held in the strictest confidence, including the fact that you are a client at this center. When a minor client is involved in individual therapy, the parent or guardian has the right to ask for information about the minor client's therapy, and the therapist, acting in the best interest of the minor client, has the right to limit information disclosed.

The following are the only exceptions to the above mentioned confidentiality:

1. If I have a reasonable suspicion that the minor is a danger to him/herself, I will do what is necessary to attempt the prevention of a tragedy (such as admitting you to a hospital or choosing another intervention to insure your safety.)
2. If I have a reasonable suspicion that the minor is a danger to another person, I have an obligation to either warn that person and others who may be effected, and I may need to call the police.
3. If I have a reasonable suspicion that the minor is a victim of abuse I have an obligation to call Child Protective Services or the police.
4. If I have a reasonable suspicion that the minor is involved in the abuse of an elder adult, I have an obligation to call Adult Protective Services or the police.
5. If I receive a court order to release records, I will always consult you and your attorney prior to any release of information.

I am a:

____ Licensed Marriage, Family and Child Therapist.

____ Registered Marriage, Family and Child Intern.
If this space is checked, then your therapist is an intern in the process of obtaining 3,000 hours required to take the marriage and family therapist licensing exams. Interns have completed their master's degrees and are studying under a licensed therapist until they have passed their examinations. Your therapist will be meeting weekly with his/her supervisor, Kristen Crichton, LMFT, in order to discuss his/her cases each week. Your therapist's supervisor will maintain the confidentiality of your case, as required by mental health laws, and your session will only be discussed in order to ensure the best therapy possible. Occasionally, your therapist may be asked to record one of your sessions. The audio or videotape will be erased after supervision and you will never be recorded without your knowledge and explicit permission.

As you know, this is a professional relationship. I want to help you understand yourself better and help you improve your relationship with others. Large numbers of studies indicate that practicing a mainstream faith confers significant health benefits, especially mental health benefits, and that people who use “religious coping” (i.e. prayer, confession, seeking strength and comfort from God) adjust better to stressful events. I want you to know that I am a Christian and am perfectly willing to work with your spiritual needs as well as your physical, emotional and cognitive needs if you should choose. Please let me know if this is something your child would like to address.

The fee is ____ per 50 minute clinical hour. Sessions start at the time we agree and end 50 minutes later. Except for calls under 10 minutes or brief reports, I charge for report writing, phone therapy, email responses or other professional services at a rate of ____ per hour in 15-minute intervals. Please help me maintain time limits and use your time wisely.

You are responsible for payment services should there be any non-coverage from your insurance company. **Initials:** _____

I ask for a 24-hour cancellation notification prior to appointment unless there is an emergency. Failure to do this will result in billing for the entire missed appointment fee as I do not bill insurance companies on missed appointments. **Initials:** _____

You are free to terminate therapy at any time. It will be beneficial to discuss termination together so we will have adequate time to prepare for it.

Minor Client Name: _____ Phone: _____

Address _____ City: _____

State: _____ Zip Code: _____

Responsible Party for Minor Client

Name: _____ Phone: _____

Address _____ City: _____

State: _____ Zip Code: _____

Relationship to Client _____

Consent to Treat

_____, parent or guardian of

_____ minor client, gives permission for the

therapist, _____ to provide individual therapy to minor client.

Please sign and date below after you have read and fully understand the Consent to Treat Minor above.

_____ _____
Signature of parent/guardian Date

_____ _____
Signature of minor client Date

_____ _____
Signature of therapist Date