Roots & Wings Consulting

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. Email and text messaging are acceptable forms of communication for scheduling and cancellations, but cannot be considered 100% confidential, and ARE NOT RELIABLE FOR CONTACTING A THERAPIST WHEN IN CRISIS.

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