Minor Consent for Treatment

DATE: _____

This is to certify that I/we (parent/guardian), _____, have legal custody or guardianship of the following child(ren) and have the legal right to authorize the care, treatment, and counsel of this/these child(ren):

Name of Child: _____ Date of Birth: _____

Please complete one Minor Consent for Treatment per child.

I give consent for him/her/them to receive services from Secure Counseling Clinic.

I **further consent**, in the interest of maximizing the effectiveness of the services provided, that the content of this counseling, with the exception of the content of any given sessions where I may be invited to be present, will be considered confidential and **will not be divulged to me without my child's knowledge or consent**. I agree to give my child's privacy the same confidentiality as afforded to an adult who has individual sessions.

I understand that if my child is in danger of **suicide/homicide** (life-threatening concerns), if a court **subpoenas** my child's therapy records or counselor appearance, or my counselor is being emotionally, physically, verbally, or sexually **abused/ neglected**, my counselor is **legally mandated to report** possible to appropriate authorities, as well as make mandated appearances. A child's records are considered privileged in a court setting, and our practice believes in protecting the privacy of your child's therapy work, even in the context of the judicial system. Our clinicians generally will advocate for clients in the court system when it would be therapeutically helpful by writing letters, consulting when appropriate, or other forms of advocacy; however, therapy files are heavily protected.

Working with children and teens who self-harm or self-mutilate is complex. Our clinicians see self-harm as a symptom of deeper, underlying problems that need to be the focus, as opposed to the harm activity itself being the focus of treatment goals. Our clinicians evaluate self-harm based on the level of threat of **infection** or **life-threatening,** serious bodily harm. Self-harm activities are generally (although not always) a **coping mechanism**, rather than being evidence of suicidal ideation. Your child's clinician will assess suicidality, as they would in any constellation of other symptoms. While we understand that parents *want to know*, sometimes **clinicians will wait** and give time for the child to process these self-harming activities, find words to describe their reasons/feelings/purpose for self-harm activities before sharing this information with parents. Clinicians encourage minors to share themselves with caregivers when they are ready, so they feel empowerment rather than betrayal.

As the parent/guardian, **I agree to participate in the above child(ren)'s therapy treatment by possibly attending parent sessions, classes, and/or implementing interventions at home that my counselor recommends.** I understand that my child(ren)'s therapy progress does heavily rely on my ability to follow treatment recommendations on the child's behalf. I understand that the responsibility for change **does not lie solely with my child**, but with my child's family and social system.

I acknowledge that all clients will take from a session what they want or need to take away. This **take-away may be the same or different** recollection of session content as the clinician or other counseling participants. I acknowledge that there might be **discrepancies** between what my child says was said in session (*"My therapist says you are…."*, or "*My therapist told me it was ok to eat ice cream at midnight and watch 10 hours of YouTube."*), and that a clinician reflecting wishes/thoughts of a client is not the same as giving permission. I understand that **my child's emotional needs may not be the same as my own emotional needs as a parent.** I understand that sometimes this can create tension with a clinician or feel difficult for me as a parent, and **I agree to process this in therapy with the clinician, as it's *part of treatment*.**

I acknowledge that my child must form a **connection with their therapist** in order to do this emotional work. I acknowledge that I have a **unique power over the therapeutic relationship as a parent** because I will schedule and provide funding for their counseling journey. I understand this might be **difficult for my child** should I find that counseling is a financial burden I am no longer able or want to accommodate, should I become angry or dissatisfied with my child's goals for treatment or the pace of treatment not matching with my own expectations, or should I choose to terminate counseling without consulting with my child and their therapist. **I will discuss a shift** to maintenance frequency of sessions or a termination with my child's therapist thoughtfully, and **I will allow** my child to have a "goodbye session" when needed.

Only one custodial parent/guardian signature required for treatment.

(Required) Legal Custodial Parent/Guardian Signature _____ Date _____

Legal Custodial Parent/Guardian Signature _____ Date _____