

**CONSENT TO TREATMENT OF A CHILD**

Name of child: \_\_\_\_\_

The named therapist below and I have discussed my child's circumstances. I acknowledge that I have received information about the therapy I am considering for my child and my questions have been answered fully.

I do hereby seek and consent to take part in the treatment for my child by the therapist named below. I understand that developing a treatment plan and reviewing our progress regularly with this therapist are in my child's best interest towards meeting the treatment goals.

I agree to play an active role in this process and will always be available to the therapist while my child is in therapy sessions. I agree that I am responsible for my child and **will not leave the grounds** while my child is in his/her therapy session. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type, cost, dates and providers of any services or treatment my child receives. I understand that if payment for the services received here is not made, the therapist may discontinue treatment. I also understand that I am financially responsible for any balance not covered by my insurance company.

I am aware that if I no-show three consecutive appointments for my child without contacting the office, the therapist will consider my child to be terminated from treatment. Also, if 90 days pass without scheduling an appointment for my child (unless this break is part of the treatment plan with the therapist), this therapist will consider my child to be terminated from the current course of therapy. I am aware that I can chose to discontinue my child's treatment with this therapist at any time and I will only be responsible for payment for services rendered by my child. I understand that I may lose additional services or may encounter other problems if I cease treatment. (For example, if treatment has been court ordered, I will have to answer to the court.)

It is best that minors are brought for treatment by a parent or legal guardian. However, there may be times when someone other than you may need to bring your child to their appointment. That person may be a baby-sitter, family member, etc. For these reasons, and others, **our office enforces our minor patient policy, which requires that every minor be accompanied and supervised by an adult at all times.** Our office does not provide supervision of minors, visitors or guests. Minor patients who present for an appointment without a proper guardian will not be seen and may incur a **late cancellation or missed appointment fee.**

A **Designation of Another Person to Consent for Care Form** is available so that another person other than a parent or legal guardian may accompany the child to their appointment. This person **MUST be 18 years of age or older and have a valid photo ID.** Your cooperation with this office policy is essential and is much appreciated.

I have had the chance to discuss my concerns, have my questions answered and believe I understand the treatment that is planned for my child. Therefore, I agree to play an active role in this treatment as needed, and I give this therapist permission to begin this treatment, as shown by my signature below.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Signature of Client or Guardian

\_\_\_\_\_  
Date

I, the therapist, have discussed the concerns above with the minor's parent or guardian. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent to the child's treatment.

\_\_\_\_\_  
Signature of Therapist

\_\_\_\_\_  
Date