



INFORMED CONSENT FOR TREATMENT

You have taken a very positive step by deciding to seek therapy for your child. Clients and families have the best experience when therapy is viewed as a collaborative process relying on supportive parent involvement. Anchor Point expects that clients and families will follow through with treatment recommendations in order to encourage progress and positive outcomes.

PARENT AUTHORIZATION FOR MINOR'S MENTAL HEALTH TREATMENT

By signing this form, you are indicating that you give consent for your child to receive services at Anchor Point Psychological Services. Additionally, in order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify us immediately. We will ask you to provide us with a copy of the most recent custody decree that establishes custody rights of you and the other parent, or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is our policy to notify the other parent that we are meeting with your child, as long as you both have joint legal custody. We believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, we will strive to listen carefully so that we can understand your perspectives and fully explain our perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, we will honor that decision, unless there are extraordinary circumstances. However, in most cases, we will ask that you allow us the option of having a few closing sessions with your child to appropriately end the treatment relationship.

CONFIDENTIALITY

HIPAA protects the relationship between a client and therapist, and information cannot be disclosed without the client's permission. The session content and all relevant materials to your child's treatment will remain confidential unless the child requests for the information to be shared or the therapist determines that it is clinically necessary to disclose.

There are exceptions to the confidentiality agreement between therapist and client and they are listed below:

1. Suspected abuse and/or neglect of a child, dependent adult, or elderly person currently or in the past. It is required by law that this is reported to the appropriate authorities immediately.
2. If a client is threatening serious bodily harm to another person/s, therapists must notify the police and inform the intended victim.
3. If a client expresses intent to harm himself or herself, the therapist will make every effort to engage the cooperation of the child and their parent in order to ensure their safety. If the child and/or parents does not cooperate with efforts to develop a safety plan, we will take further measures without their permission that are provided to us by law in order to ensure their safety.

INDIVIDUAL PARENT/GUARDIAN COMMUNICATIONS WITH PROVIDERS

In the course of our treatment of your child, we may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, our client is your child – not the parents/guardians, nor any siblings, or other family members of the child. If we meet with you or other family members in the course of your child's treatment, we will document that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

DISCLOSURE OF MINOR'S TREATMENT INFORMATION TO PARENTS

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is our policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, we will communicate this information to you.

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

PARENT/GUARDIAN AGREEMENT NOT TO USE MINOR’S THERAPY INFORMATION/RECORDS IN CUSTODY LITIGATION

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require helping to address conflicts between the child’s parents, my role will be strictly limited to providing treatment to your child. Additionally, involving me in your court proceedings can be damaging to my therapeutic relationship with your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent’s custody, visitation suitability, or fitness. If the court appoints a custody evaluator, best interest attorney, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at my hourly rate for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

PHYSICAL HEALTH & ILLNESSES

We are committed to providing in-person services for our clients and families. However, we can only work if we are healthy. We also have our own families to protect. Therefore, we ask for the following:

1. If your child or anyone else in your family is showing signs of illness, please communicate with your therapist about best options. We are happy to transition to telehealth or wear masks in session to ensure everyone is protected. We can also cancel the appointment and reschedule for another time when everyone is healthy (at no additional charge).
2. If your child is too sick to attend school (e.g., fever or vomiting within 24 hours), they are too ill to come to our office.

Additionally, we agree to the following:

1. If we are showing signs of illness, or others in our families, we will communicate with you about best options. We will wear masks, transition to telehealth, or reschedule appointments as needed.
2. We are happy to wear masks for any sessions in which that is the family’s preference.
3. We will continue to implement all of the safety procedures that we have been thus far in our offices. We clean surfaces regularly and run air purifiers to try to reduce the spread of any germs.

Signature of Parent/Guardian

Date