**SHARED-CUSTODY CONSENT FOR MENTAL HEALTH**

**TREATMENT OF A MINOR**

**Therapist Qualifications**

Psychotherapists have professional training in conducting mental health treatment. You have the right to inquire fully about the credentials, education, and experience of your child’s therapist and to have your questions answered to your satisfaction. In this practice, treatment is provided either by a licensed member of a mental health profession (psychology, psychiatry, social work, or counseling) or else by an unlicensed professional with training enabling him or her to practice under the supervision of a licensed professional. If your child’s therapist is an unlicensed professional, you should receive an explanation of the supervision arrangement and the name and phone number of the supervisor. You have the right to discuss your child’s treatment with the supervisor.

**What to Expect from Treatment**

Your child’s therapist will work to provide the most effective treatment possible. Studies of psychotherapy indicate that most clients benefit from treatment and experience improvement in the problem areas for which services were south. However, treatment benefits, while likely, cannot be guaranteed. Response to therapy is different for each client and should be discussed on an ongoing basis with your child’s therapist.

Psychotherapy can involve a variety of different activities, which vary from client to client. In general, your therapist will assess your child’s problems and then will provide therapeutic services designed to resolve or reduce the problems. There may be individual work with your child, discussions with you possibly including ways to help your child outside of therapy, and/or family sessions. Therapy may focus on feelings, thoughts, relationships, and/or behaviors. With young children, therapy generally includes play activities used as a means of understanding and communicating with the child.

**Confidentiality**

Historically, psychotherapy was associated with complete confidentiality between the family and clinician. Currently, both law and professional ethics require therapists to maintain complete confidentiality in the vast majority of cases. In these cases, the therapist cannot release any information about your family without your expressed permission. However, as a result of legal developments, there are some exceptional circumstances in which therapists are required to communicate information about therapy to persons outside the family. These exceptions include the following situations:

* The client presents a clear and present danger to himself or herself and refuses to accept appropriate treatment.
* The client communicates to the therapist a threat of physical violence against a clearly identified or reasonably identifiable victim, or the therapist has a reasonable basis to believe there is a clear and present danger of physical violence against such a victim.
* The client introduces his or her mental condition as a defense in a legal proceeding.
* In child custody or adoption cases, the judge determines that the therapist has information bearing significantly on the client’s ability to provide suitable care.
* The client initiates legal action against the therapist.
* The therapist has grounds to believe a child under the age of 18 or an elderly person (over the age of 60), or handicapped adult, has been, or is at risk of being abused or neglected.
* The therapist has reason to believe that a child was prenatally exposed to a potentially addictive or harmful drug or controlled substance.
* The therapist has reason to believe a health care professional has engaged in professional misconduct.
* A judge orders the therapist to release client information.

**Financial Arrangements**

* The initial appointment is a diagnostic intake session with a fee of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Subsequent therapy sessions are 50 minutes in length and have a fee of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

* We will follow your instructions to assist you in obtaining insurance reimbursement for our services. However, the final responsibility of paying for treatment is yours. This means that if insurance does not provide the reimbursement you expect or desire, the full balance is your responsibility.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, indicate by my signature on this form that I consent to the mental health treatment of the child, and that I understand and consent to the conditions described above.

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Signature Date