

## Minor Treatment Consent

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It is important that you are fully informed about the counseling services your child will be receiving. Your signature below indicates that you have received, read, and understand the policies of the therapist with whom your child will work.

1. I understand that this therapist is bound by certain federal and state laws regarding what she may/may not disclose to the parents of minors; the therapist also willingly adheres to the Code of Ethics of the American Counseling Association (ACA) and/or the International Association of Marriage and Family Therapists (IAMFT).

2. I understand that confidentiality is maintained except for the following situations:  
-when a minor is dangerous to self or others  
-when abuse of a child or dependent adult is suspected  
-in the context of supervision (see #3 below)  
-when there is a court order to release records

3. I understand that Kathy Nace, MA, LPC, NCC is under the supervision of Elizabeth Russell, LCPC (License #2384) as a condition of her present licensure (standard practice for therapists working toward their clinical certification). I further understand that in this supervisory context, information regarding my child's therapy may be discussed in a non-identifying manner for the purpose of furthering the knowledge and effectiveness of this therapist.

4. I certify that I am a custodial parent and give my permission for my child, who goes by the legal name \_\_\_\_\_, to receive counseling services.  
(print name)

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(Signature of Legal Guardian/Custodial Parent)

(Date)