

CONSENT TO TREATMENT FOR A MINOR

I, _____, the parent/legal guardian of the minor, _____,

give my permission for this minor to receive the following services/procedures/treatments/assessments:

- 1. _____
2. _____

These are for the purpose(s) of:

- 1. _____
2. _____

Services are to be provided by Afete clinicians or by another professional as the therapist/parent sees fit. The fees for these services will be \$ _____ for the initial 1.5 hour Intake, and \$ _____ per hour of service ongoing, or \$ _____ for the full services.

This therapist's office policies concerning missed appointments have been explained to me. I have been told about the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both this minor and his or her family.

I agree that this professional may also interview, assess, or treat these other persons:

Due to the laws of this state and the guidelines of the therapist's profession, your child has certain rights regarding confidentiality in treatment. Arête's policy is to make every effort to foster open communication and disclosure when clinically indicated between family members, however we will adhere to applicable APA guidelines and state laws when mandated. Please see the Rights of Clients form for further information.

My signature below means that I understand and agree with all of the points above.

_____/_____
Signature of parent/guardian & adolescent Date

I, the therapist, have discussed the issues above with the minor, and their parent or guardian. It is my professional judgment that these persons are fully competent to give informed and willing consent to this course of treatment.

Signature of therapist Date

- Copy accepted by parent/adolescent Copy kept by therapist

This is a strictly confidential patient medical record. Redislosure or transfer is expressly prohibited by law.

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