

Consent to Treat Children and Adolescents:

Therapy is most effective when a trusting relationship exists between therapist and patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will acknowledge that we will provide your child with age-appropriate privacy and confidentiality. It is our policy to provide you with general information about treatment status. We will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, we will share that information with you. We will not share with you what your child has disclosed without your child's consent. We will tell you if your child does not attend sessions. We will share general information such as issues discussed, progress made, and what other areas are likely to require intervention in the future. The details will vary with the age of your child and the specific situation-your therapist will clarify these issues in the initial session(s). If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Some of these behaviors may be minor problems, but at other times they may require parental intervention. Feel free to discuss with your therapist any concerns you have about how these issues will be addressed. If we ever believe that your child is at serious risk of harming him/herself or another, we will inform you.

The following is specific to potential custody or other legal disputes:

I am aware that requesting the release of treatment plans, notes or reports in custody disputes, or subpoenaing testimony about any of the content of my child's treatment, interferes with the therapy relationship and jeopardizes any gains made in psychotherapy. Therapists must be able to be neutral in family legal conflicts to be helpful. I agree that the role of Cornerstone Counseling and Wellness, LLC is limited to providing treatment and that I will not involve Cornerstone Counseling and Wellness, LLC in legal disputes, especially a dispute concerning custody, custody arrangements, visitation, etc. Therefore, I knowingly and freely waive my right to request the release of information to myself or my attorney or any other Officer of the Court for such disputes. I agree to instruct my attorneys not to subpoena Cornerstone Counseling and Wellness, LLC or its staff, or to refer in any court filings to what Cornerstone Counseling and Wellness, LLC staff has said or done. Except for records of attendance and billing, I understand that release of clinically significant information shall be by Court Order, signed by a duly appointed Judge.

If there is a court appointed evaluator in a custody dispute, and if appropriate releases are signed by both parents and a court order is provided, Cornerstone Counseling and Wellness, LLC will provide general information about the child which will not include recommendations concerning custody or custody arrangements. If for any reason, Cornerstone Counseling and Wellness, LLC staff are required to appear as a witness or speak to a custody evaluator or judge, time spent preparing reports, traveling, reviewing files, or other case-related costs will be charged at a non-insurance based rate to the party responsible.

Both parents must consent for treatment unless the treatment is court ordered or one parent is sole legal custodian.

CHILD'S NAME _____ DATE _____

PRINT NAME _____ (RELATIONSHIP) (FOR MINORS, AGE) _____ SIGNATURE _____ DATE _____

PRINT NAME _____ (RELATIONSHIP) (FOR MINORS, AGE) _____ SIGNATURE _____ DATE _____