CROSSROADS
COUNSELING & PSYCHOTHERAPY

Consent for Treatment of a Minor Child

Child's Name: _____Date of Birth: _____

I, _____, give my consent to Crossroads Counseling & Psychotherapy, LLC to provide treatment and therapy determined to be necessary or advisable for my child who is named above. I understand that I may stop treatment for my child at any time and that Crossroads Counseling & Psychotherapy, LLC may also stop treatment after discussion of the reasons for termination and referral to other professionals, if needed.

I realize that my child's treatment is confidential. Information may not be released without my written consent except a) in the event that an issue is raised which, in the therapist's judgment, would endanger my child's welfare, or b) another exception to Confidentiality occurred (See "Statement of Confidentiality"). If my child is 14 years or older, I understand that s/he must sign a Release of Information for me to receive information about the treatment unless the child is at risk (See "Statement of Confidentiality") in which case the therapist will notify the proper authorities.

My child's therapist may determine with my child that my participation is needed to treat a specific problem. In that event, I am prepared to participate in my child's treatment as requested.

If I am separated or divorced from my child's other parent, I will provide legal documentation of my authority to sign this Consent for Treatment of a Minor Child. In addition, I agree to work cooperatively with the therapist to deal with issues related to this matter.

_____ _____

Signature of Parent/Legal Guardian Date

_____

Address

_____

_____ _____

Witness and Title Signature of Child (if 14 or older)