

**Consent for Treatment of Minor**

Client’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Treatment**

I authorize and request that Healthy Minds Counseling Services, Inc. provide the psycho-therapeutic services determined to be clinically appropriate for my child/myself. I understand that the primary goal of these services is to help my child be at his/her most successful emotionally, socially and academically. I understand that I have the right and responsibility to be informed of my child's progress. I understand that Healthy Minds Counseling Services, Inc. will review my child's progress in therapy with me, and that I will work as a team with Healthy Minds Counseling Services, Inc. by providing feedback and observations regarding my child.

**Consent to Treatment of Minors**

I hereby represent that I have the legal authority to obtain medical treatment and counseling for the minor child for whom I am requesting treatment. I am a biological parent or legal guardian. If group home or foster family settings, I am designated to authorize treatment. If divorced, I am the primary custodial parent and can secure treatment without the authorization of the other parent.

**Limits of Relationship and Confidentiality**

I understand that communications between a client and clinician are confidential and protected by law. I also understand that exceptions include when a client is a danger to themselves or to others, or when there is a reasonable suspicion of child or elder abuse.

**Release of information and Authorization for Payment**

I hereby authorize Healthy Minds Counseling, Inc. to release information regarding my child’s condition and treatment to Medicare, Medicaid, and/or other insurance carried by the client. I authorize payment or medical benefits to Healthy Minds Counseling, Inc. for services provided.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (Parent/Guardian) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Parent/Guardian