



Agreement for Psychotherapy with a Minor

I, _____, the parent/legal guardian of the minor, _____, give my permission for this minor to receive psychotherapeutic services and assessments if necessary to receive the most appropriate level of care. All services are voluntary and may be canceled at any time.

These services are to be provided by the therapist named above. The fees for these services will be \$ 120.00 per session of service.

I understand that there is a \$40.00 charge for missed appointments with less than 24 hour notice.

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 understand that all information will be kept confidential and will not be discussed outside the sessions without prior written consent. Records will be retained and all data will be kept confidential according to all applicable state and federal laws. Law compels all therapists to take action to protect people by informing appropriate persons and/ or informing the other person if it is believed that your child is in imminent danger of causing serious harm to him/herself or another person(s). The therapist is mandated to report any reasonable suspicion that a child, dependent adult, and/or elderly adult have been abused.

I am the legal custodian of this child, and there are no court orders in effect that would prohibit me from consenting to the treatment of this child.

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

Signature of parent/guardian

Date

I, Jenifer Finkelstein, the therapist, have discussed the issues above with the minor client’s parent or guardian. My observations of this person’s behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent to the minor client’s treatment.

Signature of therapist

Date

_____ I acknowledge that I have received a copy of the Notice of Privacy Policies.

_____ Copy accepted by parent/guardian _____ Copy kept by therapist

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