**Davis Counseling & Play Therapy Center, PLLC**

**Statement of Informed Consent with Minors (under the age of 18)**

I, (printed name of parent/legal guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

give consent for (printed name of client/minor child) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

age \_\_\_\_\_\_\_\_\_, (date of birth) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to receive counseling services and treatment from Suzanne Davis, LPC, RPT-S (counselor).

I understand this therapeutic relationship is voluntary and there are certain risks involved, such as the sharing of personal information about the child and/or their family. I understand that I or my child may discontinue treatment at any time; however, there might be risks involved in discontinuing treatment early. The scope and nature of this treatment has been explained to me and I understand that there are no guarantees for treatment outcomes. I agree to hold harmless and indemnify the counselor and/or her staff from any damages, suits, claims, or liabilities arising from this therapeutic relationship.

\_\_\_\_\_\_\_\_\_ (Initials) I understand that my participation in my child’s therapeutic process (e.g., parent sessions) are a critical part of my child/adolescent’s counseling experience at Davis Counseling & Play Therapy Center PLLC. I understand that my involvement in the parent sessions is treated as a team and collaborative approach between myself and the counselor where the counselor provides, but not limited to, parenting skills/strategies to increase understanding, promote child well-being, and psycho-education. I understand that all parent sessions are subject to the same confidential guidelines and requirements that are noted by applicable state and federal laws.

**Confidentiality/Duty to Report**

I understand that confidentiality will be maintained at all times within legal requirements of the Commonwealth of Virginia and by federal law as noted in the Health Insurance Portability and Accountability Act (HIPAA),and ethical guidelines according to the American Counseling Association Code of Ethics and the Association for Play Therapy Best Practices*.*

\_\_\_\_\_\_\_\_\_ (Initials) ***I understand that confidentiality will not be maintained if my child threatens or gives reason to believe that he/she will harm themselves or others. In addition, Commonwealth of Virginia laws requires that if the therapist suspects or has knowledge of any form of sexual or physical abuse of a child, it must be reported immediately to the proper authorities.*** If client(s) is(are) involved in family/marital counseling, it is encouraged that each participant maintain a “no secrets” policy, meaning that issues be addressed openly and honestly during the sessions.

In certain cases, parents do have a right to access your child’s medical records. However, it is the policy of this counselor to maintain confidentially with the child, except in the cases outlined above. The counselor will periodically keep the parents informed of the general progress of their child, but will not give details of what occurs or is said in sessions. If there is information that the counselor feels might be beneficial for the child to share with the parent(s), the counselor will work with that child on how to appropriately share that information with the parent(s), including possible joint sessions with the parent(s) or family sessions.

\_\_\_\_\_\_\_\_\_ (Initials) It is the policy of this counselor that when counseling with minors (clients under the age of 18), that ***the parent or legal guardian must remain in the building during the counseling session*.** Confidentiality is a very important part of counseling. However, a child’s or adolescent’s safety is just as important. If for any reason you feel uncomfortable with your child or adolescent meeting alone with the counselor, please make this known to the counselor so that other arrangements or referral to another counselor can be made. If you suspect abuse by the counselor, please report this immediately to Child Protective Services \_\_\_\_\_\_\_(Initials)

**Privacy of Information (HIPAA)**

\_\_\_\_\_\_\_\_\_ (Initials) I acknowledge that I have been given a copy of the counselor’s *Health Insurance Portability and Accountability Act (HIPAA) Patient Notification of Privacy Rights* which describes how records and information about my treatment will be handled.

**Credentials and Supervision**

The counselor is licensed by the Commonwealth of Virginia as a Licensed Professional Counselor through the Virginia Board of Counseling and is a Registered Play Therapist-Supervisor through the Association for Play Therapy.

\_\_\_\_\_\_\_\_\_ (Initials) The credentials of the counselor have been explained to me.

I understand that the counselor will, on occasion, participate in clinical supervision and/or clinical consultation with other counseling professionals. Cases will be discussed with other counseling professionals solely for the purpose of gaining additional perspective, input and treatment direction. Confidentiality will be maintained in this supervision and/or consultation, and the names of clients will not be used or disclosed.

**Fees**

\_\_\_\_\_\_\_\_\_ (Initials) I understand the fees involved in this treatment and that payment is expected at the time of the counseling session, unless other arrangements have been made and agreed upon with and by the counselor. I also understand that failure to pay the expected fee could terminate treatment and the settlement of any unpaid fees that may be turned over to a collection agency.

**Appointments**

**The length of individual counseling sessions and parent sessions are 50-60 minutes, and family sessions with the minor client present are 60-75 minutes.** I understand that appointments should be kept and that I should arrive on time for scheduled appointments. If the client is late for the session, the session time will be cut short based on the allotted time for the session.

\_\_\_\_\_\_\_\_(Initials) ***If the client is more than 15 minutes late for a scheduled appointment, the appointment will be considered as a “no show” and will need to be rescheduled.* *“No shows” for appointments are subject to being charged a $50 no show/late cancellation fee.* *Cancellations need to be made 24 hours prior to scheduled appointments, except in the case of family or medical emergencies.***

**By signing below, I agree and acknowledge that I understand the terms and conditions in the Statement of Informed Consent with Minors:**

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_