**Rebecca English Counseling**

**Statement of Informed Consent**

**With Minors (under the age of 18)**

I (name of parent/guardian) give consent for

(client/ minor child) age (date of birth) to receive psychotherapy and treatment from Rebecca English Counseling . I understand that this therapeutic relationship is voluntary and that are certain risks are involved, such as the sharing of personal information about the child and/or their family. I understand that I or my child may terminate treatment at any time, however there might be risks involved in terminating 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 therapist and/or his staff from any damages, suits, claims, or liabilities arising from this therapeutic relationship.

**Confidentiality/Duty to Report**

I understand that confidentiality will be maintained at all times within legal requirements of the State of New York and ethical guidelines according to the NASW Code of Ethics***. I understand that confidentiality will not be maintained if the child threatens or gives reason to believe that they will harm themselves or others. In addition, State of New York 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 involved in family therapy, it is encouraged that each participant maintains a “no secrets” policy and that issues be addressed openly and honestly during the sessions.

In certain cases, parents do have a right to access a child’s medical records. However, it is the policy of this therapist to maintain confidentially with the child, except in the cases outlined above. The therapist 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 therapist feels might be beneficial for the child to share with the parent(s), the therapist will work with that child on how to appropriately share that information with the parent(s), including possible joint sessions with the parent(s).

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

**Privacy of Information (HIPAA)**

I acknowledge that I have been given a copy of the therapist’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 Therapist is licensed by the State of New York as an LCSW. I understand that the therapist will, on occasion, participate in clinical supervision 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 the names of clients will not be used. The credentials of the therapist have been explained to me.

***(Please see next page…)***

**Fees**

I understand the fees involved in this treatment and that payment is expected at the time of the session(s), unless other arrangements have been made. I also understand that failure to pay the expected fee could terminate treatment and the settlement of any unpaid fees will be turned over to a collection agency.

**Cancelation Policy**

I agree to provide 24-hour advanced notice for cancelation of appointments with the exception of a medical emergency or severe weather. I understand that I will be obligated to pay for the missed appointment if I don’t provide advanced notice.

By signing below, I agree that I understand and agree to the above policies and procedures and this Statement of Informed Consent with Minors:

**Client Date**

**Parent/Guardian Date**

**Therapist Date**