Parental Consent for Child/Young person Therapy

Name of Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child’s confidentiality during the course of his/her treatment.

Therapy is most effective when a trusting relationship exists between the therapist and a child. Privacy is especially important in securing and maintaining that trust. It is necessary for children to establish a “zone of privacy” with their therapist that allows them to feel free to discuss personal matters. Therefore, it is my policy to provide you with general information about the treatment of your child, but I will not share with you what your child has disclosed to me without your child’s consent. However, if I ever believe that your child has been abused or is at serious risk of harming him/herself or another, I will inform you. I will be happy to provide a written treatment summary upon request.

Adolescence is a time when children need to develop a greater sense of independence and autonomy. If your child is an adolescent, it is possible that he/she will reveal sensitive information during therapy sessions regarding sexual contact, alcohol and/or drug use, or other potentially problematic behaviours. In order for me to effectively work with your child, it is necessary for me to maintain confidentiality about these behaviours unless they involve imminent risk of harm to self or others , such as driving while under the influence of alcohol or drugs. I will also inform you if your child does not attend sessions or if it is necessary to refer your child to another mental health professional.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and a therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully and try to understand your perspectives, while fully explaining mine. We can resolve such disagreements, or we can agree to disagree, so long as this enables your child’s therapeutic progress. If either parent decides that therapy should end, I ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

**Fees:** Each session will last for 55 minutes, usually weekly with the fee of £45 payable at the end of each session by cash, contactless payment or Paypal. Fees are reviewed annually and if a fee increase is due I will give you 1 months’ notice of any increase. Parents/guardians of children under the age of 18 are responsible for the payment of fees.

Thank you for your understanding and cooperation. If you have any questions about the information contained in this contract, please discuss them with me prior to signing below. Your signature indicates legally binding agreement with the terms set forth in this contract.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature

Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_