Thriving Lives Counseling

INFORMED CONSENT TO TREAT A MINOR

Thank you for choosing Thriving Lives Counseling, LLC. Today's appointment will take approximately 60 minutes. This document is intended to inform you of our policies, State and Federal Laws and your rights. Treatment practices, philosophy and plan as well as treatment limitations and risks will be discussed with you today.
Beginning counseling is a major decision and you may have many questions. If you have other questions or concerns, please ask and your clinician will try their best to give you all the information you need. Please direct further questions to the practice manager if your clinician is not able to provide you with clarification.

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS

Name of Child: _____Date of Birth: _____
Child is 12 years of Age or Older: ☐ Yes ☐No

CONSENT:
By signing this form I/we (guardian and child 12 years of age or older) hereby give consent for Thriving Lives Counseling, LLC to provide therapy services, assessments, or other mental health services to myself and/or my child.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

I/we understand that there may be some aspects of therapy that I will not have disclosed to me, as guardian or parent, for the sake of building trust with my child, and depending on the age of that child, there are some aspects of therapy that I will not legally have access to without my child's consent.
Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical, sexual abuse or elder abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you are determined to be a clear and present danger to yourself or others, e) information necessary for case supervision or consultation and f) or when required by law.

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If an emergency situation for which the client or their guardian feels immediate attention is necessary, please call the office to have a counselor contacted. If no call is received within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Your therapist will follow those emergency services with standard counseling and support to the client or the client's family. E-mail, text messages and social networking sites are not confidential and I may not be able to respond.

ADDITIONAL RIGHTS AND UNDERSTANDINGS:
I understand that I have a right to obtain certain treatment information at any time by law, such as diagnosis, services rendered, treatment plan, etc. This may not include certain details regarding the content of therapy. Any other parent or legal guardian (even if not living with the child) may have similar rights.

I understand that involving my child in therapy does not qualify as a custody evaluation in divorce proceedings. Custody evaluations require a very specific type of procedure and qualified professional, and my therapist's impressions will not be sufficient for this purpose.

By signing this document, I/we consent to my child's participation in treatment, and affirm that I/we have the legal authority to give such consent.

Name (please print): _____
Relationship to Client: _____

Signature: _____ ***Date:*** _____

*Signature of Client, if over the age of 12:

Signature of client: _____***Date:*** _____