



THE COUNSELING CENTER

Date: _____

To the Parent of: _____

Re: Parental Consent for Treatment

Acct. #: _____ Email: _____

Please complete the following form, sign below, and mail or fax this form back to the Counseling Center. The Counseling Center of Nashua's address is 1 Main Street, Nashua, NH 03064 and our fax number is 603-883-0007.

The Counseling Center has been contacted to schedule an Intake/Assessment appointment for (please fill in your child's name & DOB):

Child's Name: _____ Child's DOB: _____

Relationship to Child: _____ Mother _____ Father _____ Guardian

_____ I give my consent for my child to receive the following treatment (initial next to those treatments for which consent is given):

- _____ Individual Therapy
- _____ Family Therapy
- _____ Group Therapy
- _____ Psychiatric treatment/Medication Management
- _____ Psychological/Neuropsychological Testing

_____ I give my consent for treatment and would like to be actively involved in my child's treatment. Please contact me at _____ to schedule an appointment time during which I can also meet with the therapist.

_____ I give consent for treatment and may at some point wish to be involved in my child's treatment. Please have the treating provider contact me after the initial evaluation so we can discuss this. I can be reached at _____.

_____ I give my consent for treatment but do not wish to be involved at this time.

_____ I do not give my consent for treatment.

Sincerely,

Parent's Signature

Date

Please Print Parent's Name

Patient Name: ~patient.first~ ~patient.last~ DOB: ~patient.birth~

Dear Parent:

The following is The Counseling Center's Policies with respect to treatment of children and adolescents whose parents who are divorced. While many divorces are amicable with parents working collaboratively for the good of the children, others may be contentious. While in many cases the issues discussed here may never arise, we have found it beneficial to make everyone aware of the policies and protocols of The Counseling Center with respect to treatment of children and adolescents whose parents who are divorced. The following are guidelines and understandings we need to have with you in order to provide the best possible care for your child or family. For us to schedule your child for counseling, and/or a medication evaluation, we require that the attached consent be signed by each parent to indicate review and acceptance.

Please carefully read and initial the following to verify your understanding of our policies

___ It is preferable that both parents be involved in treatment and communicate with their child's provider directly. If information is to be shared with the child's provider, the parent should make every effort to attend the session, or at the discretion of the therapist, to be scheduled at alternate appointment times to accommodate the different schedules of each parent. If conjoint appointment times cannot be arranged in the office for this purpose, it will be the non-attending parent's financial responsibility to pay for all outside-of-session time required to convey this information. This includes making phone calls outside of the scheduled session time, listening to voicemail messages, and reading written statements mailed or emailed. Any email communication sent by a parent will be deemed as consent given for the provider to review the information and respond as needed (carbon copied to both parents), and the account will be billed accordingly at our established fee schedule.

___ It is not the responsibility of the provider to monitor who is financially responsible for balances on the account. Bills will be sent to the account responsible and we ask parents to work together, or in conjunction with their lawyers, to clarify any billing issues. All copays, forensic fees, and other fees are to be paid at the time services are delivered. Failure to pay a bill within 30 days of receipt (even if it is due to a parents' belief that the other parent is financially responsible) may result in discontinuation of services until the balance is paid or an appropriate payment plan is arranged. Please indicate here who will be the account responsible party to whom bills will be mailed: Name: _____ and address: _____.

___ Counseling appointments may at times involve only the child, one or both parents alone or together, or siblings if in family meetings. The provider is responsible for ultimately determining the most appropriate treatment plan to meet the counseling needs of the child. Your child's provider reserves the right to request child-only sessions if conflict surrounding the divorce causes problems in the treatment. Any effort on a parents' part to dictate how care is delivered may be grounds for termination of care, as appropriate care cannot be dictated by anyone other than the provider delivering care to your child or family.

___ Although parents have legal rights to the content of their child's records, it is generally not in the child's best interest for parents to request these records, especially in contentious divorce cases. Children will not share their feelings openly with their therapist if they believe their statements will be brought into court or used by one parent against another. Releasing records under these circumstances may damage the therapeutic relationship. The American Psychological Association Ethical Standards and NH case law (Berg v Berg) make clear that a child has the ethical right to privacy when disclosure is not in the best interest of the child. Therefore, you are agreeing to waive your legal right to obtain a copy of your child's clinical record for personal review or review by your attorney. Copies of your child's record may only be released to an appointed Guardian ad Litem or directly to the court. To obtain information regarding care your child has received, you may obtain this information by either: (1) scheduling an appointment for yourself (understanding that the other parent will be invited for this appointment or will be offered a similar appointment to obtain the same information), or (2) by requesting a written summary of

the care provided to your child (with the understanding that the time involved in writing such a review is billed at established fees for professional time spent).

Patient Name: ~patient.first~ ~patient.last~ DOB: ~patient.birth~ page 2

____ If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

____ Unless agreed upon at the outset of treatment, your child's provider is acting in the role of therapist and not in the role of custody evaluator. As such, the provider is not able to make recommendations regarding custody, visitation, or other aspects of a parenting plan. Decisions regarding visitation and custody are to be made only by the courts or others designated to act in this role. Your child's provider may speak with a GAL or a lawyer, with an appropriately signed release, or upon request may provide a written statement regarding general clinical impressions and recommendations to a designated party. Any written information provided to one party's attorney will automatically be sent to the other parent or their attorney. All such activities are subject to the forensic fee schedule. Both parents are required to read and sign our forensic fee schedule. If it appears at the outset of treatment that collateral time (i.e. any time spent outside of the scheduled session time) will be required, a retainer may be requested. The amount would depend on the amount of collateral time reasonably expected, with a higher amount required in more highly conflicted divorce situations. Any retainers collected would be used only for the forensic expenses, not ongoing treatment. If used to pay for collateral time spent, both parties agree to replenish the retainer amount if so requested by the provider. Failure to provide a retainer, upon request, or replenish a base retainer amount, may be grounds for discontinuing care. In the event that no collateral time is used during the course of treatment, these funds will be refunded upon the completion of care to the parent or parents who made the initial retainer payment.

____ We limit treatment solely to that which will benefit your child. We treat anything that is said in session as confidential, and ask that neither parent attempt to use my involvement with your children to obtain an advantage in any legal proceeding. In seeking treatment with me you are agreeing not to ask me to testify in Court, nor allow either Attorney to subpoena me or to refer in any court filing to anything I have said or done. If a Judge should require my testimony (I will work to prevent such an event), I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, Guardian ad Litem, or parenting coordinator, with appropriate signed releases I will provide necessary information. If I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the hourly rate of our forensic fee schedule for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs

____ In the event that either parent requests that treatment be discontinued, consideration must be given to what is in the best interests of the child at that time, as well as to legal and ethical factors affecting discontinuation of care. An abrupt termination of treatment due to parental disagreement is rarely in the child's best interest, and it is preferable that the parents speak directly with the provider about their concerns. In some rare cases if the provider determines that abruptly discontinuing treatment will have an adverse clinical or medical outcome for your child, and would therefore constitute medical neglect under the NH Child Abuse and Neglect Statute, the provider may be obligated to file a mandated report to the Department of Children, Youth and Families, if a parent insisted on an abrupt and harmful termination of care...

____ If either parent engages in behavior that the provider finds intimidating or threatening (including threatening to bring lawsuits or complaints), it may be necessary for the provider to discontinue treatment at their discretion and in consultation with the Director or Associate Director as threats such as these often create a conflict of interest for the provider.

Parent Signature

Date

Please Print Parent's Name