Aloha Counselors, LLC

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Consent to Treatment of an Adolescent

Name of adolescent client: _____

The therapist named below and I have discussed my child's situation, which briefly is:

_____

_____

_____.

I have been informed of the risks and benefits of therapy. The treatment includes an eclectic approach, which includes Brainspotting (BSP), Eye Movement Desensitization and Reprocessing (EMDR), person-centered therapy (eg. empathetic listening and questioning), cognitive behavioral therapy (eg. looking at how thoughts cause emotional reactions and behaviors), creative arts therapy (eg. releasing emotions through art, music, writing), narrative therapy (eg. rewriting one's story), and mindfulness (eg. self-calming strategies).

I understand that the adolescent is the client and that in order for the counselor to maintain a therapeutic relationship with the adolescent, there must be confidentiality. Therefore, I agree to give up access to any records unless there is a concern having to do with reported or suspected child abuse, self-harm, or threats against another.

I have had my questions answered, and believe I understand the treatment that is planned. Therefore, I agree to play an active role in this treatment as needed, and I give this therapist permission to begin this treatment, as shown by my signature below.

_____ _____

Signature of parent/guardian Date

I, the therapist, have discussed the issues above with the child's parent or guardian. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent to the child's treatment.

_____ _____

Laura E. Williams, LMHC, CSAC, PhD Date

❑ Copy accepted by parent/guardian ❑ Copy kept by therapist