CONSENT FOR TREATMENT OF A MINOR

Client (minor): _____

Date of Birth: _____

This form provides consent for the treating clinician with Prismatic Counseling of Georgia, LLC to provide mental/behavioral health counseling for my child/the minor in my care as listed above.

The services my child receives may include: a therapeutic assessment/intake, counseling or therapy sessions, and potential referrals to 3rd parties for care coordination. The clinician may share website links, worksheets, and other age-appropriate information during a session; some of this information may also be sent to the parent/guardian.

I understand confidentiality applies to my child's information, session details, and treatment. I may reach out to the treating clinician, by email, to schedule time to discuss my child's progress, if needed. I understand the treating clinician may only discuss or release information specified by informed consent and a signed release of information.

*Exclusions to confidentiality of a minor: *self-harm, suicidal thoughts or behaviors, and/or sexual activity if under the age of consent in Georgia (16)* ***are*** *topics clinician will discuss with parent or guardian.*

This consent is valid for treatment of the above listed minor for the duration of counseling or until the minor client turns 18 years old.

Parent/Guardian (print): _____

Parent/Guardian (sign): _____ **Date:** _____

Sessions will be paid for by insurance or at a negotiated and agreed-upon hourly rate.

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