MINORS IN THERAPY

If you are under eighteen years of age, please be aware that the law may give your parents or guardians the right to obtain certain information about your treatment and/or examine your treatment records. However, adolescents between the ages of 13 and 17 may independently consent to (and control access to the records of) diagnosis and treatment in a crisis situations. Therapy works best when there is a therapeutic relationship built of trust and confidentiality, in particular with teenagers/adolescents, so it is my policy to request a written agreement from your parents or guardians indicating that they consent for you to participate in therapy fully, and as such, giving up access to such information and/or, to your records, that aren't relevant to share if they do not impact your safely. If they agree, I will provide them only with general information about our work together subject to your approval. While we understand there is valid parental concern about having access to elements of your treatment for your safety, it should be noted that the law gives privacy to minors 14 and older regarding certain topics such as drugs and sex, which requires the minor client to give informed consent when releasing this information. As with any client standard mandating reporting still applies, were if you are at harm to yourself or others, your parents and/or other parties would be notified immediately. The goal of therapy is to work together to help you share relevant information to your parent(s) and/or guardian(s) to best help you progress in therapy, and as needed, family session(s) will be a way to do this. And any sessions in which I need to meet with your parent(s) and/or guardians again they too will have the same level of confidentially, though again the goal is for all relevantly information to therapy to be discussed in the best way possible to progress therapy and best help you, the client.

Client's Name (print) _____

Signature _____ Date _____

Consent For Treatment Of Minor(s) & Others

I (parent or guardian name)_____ give my consent that**,** Ashlie Befus**,** of Pathways to the Heart…, LLC., to be conducting therapy with (name of client) _____.

I have been informed of the limitation to confidentiality in the Service Agreement form, which I have read and signed. By signing I acknowledge that I have legal rights to do so for the client, and that unless termination of

parental rights or legal restrictions have been made, that both parents have the same legal rights over the minor child in treatment. I will accept the judgment of, Ashlie Befus, LMFT, M.Ed, CST, in regard to releasing or sharing information obtained during the course of therapy with the minor that may endanger or jeopardize the client's wellbeing.

Parent or Guardian's Name (print) _____

Signature _____ Date _____