# JOHN C. HOUTON, PhD LPC CAADC

***"Help & Hope for Children and Families"***
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## PERMISSION TO TREAT A MINOR CHILD:

I/ We realize that during the process of treatment for Reactive Attachment Disorder, therapeutic holding has been found to be effective by numerous attachment therapists. In the process, the child/adolescent may be held by the therapist, parents, or caregivers. Physical contact and holding is nurturing, enhances attachment, and provides containment and safety. I/We consent to participate in attachment therapy that may include holding for safety purposes, narrative therapy, behavioral therapy, traditional therapy, psycho-educational activities, and parenting education.

## PERMISSION TO VIDEO TAPE:

I/ We realize that during the process of treatment for Reactive Attachment Disorder, the use of audio and video recording technology has been found to be effective by numerous attachment therapists. In the process, the child/adolescent or parents may be video taped during treatment at John Tardibuono & Associates for the purpose of educating, processing, monitoring, evaluating, and enhancing the child/family treatment process. I/ We consent to participate in being video taped. I/We consent for our child/adolescent to participate in being video taped.

I, being informed that I/ My child may be suffering from a condition(s) which requires Mental Health services, diagnosis, and or treatment, do voluntarily consent to and authorize services, including psycho education, play therapy, social skills groups, and services that the therapist may deem necessary. I acknowledge that as a participant/guardian of a child in services I am aware that there are risks to participating in mental health treatment. I acknowledge that no guarantees have been made to me or anyone else on my behalf, as to the results of such services and procedures. I acknowledge that I have received information regarding the service(s) descriptions and have had all of my questions regarding the service answered to my satisfaction. I acknowledge that during treatment, I/ my child may have new insights and or new disturbing information may come to the patient's attention in the form of images, thoughts, affect, or sensations. I understand that it is my responsibility to share these reactions with the therapist and physician.
By signing we are stating that we understand and agree to the process and to the above mentioned information.

_____ _____
Parent/Guardian of child (if child is a minor) Date

_____
Relationship to Patient

_____
Primary patient's full name printed