**Jeffrey Ulmer, Ph.D. \_\_\_\_\_\_\_\_\_\_ Clinical Psychology**

***Office address****:* ***Mailing address:***

 *Trail’s End – second floor 42 Chewuch Heights Rd.*

 *134-D Riverside Ave. Winthrop, WA 98862*

 *Winthrop, WA 98862*

*509 996-2606* ***(phone****)* ***email:****julmerphd@gmail.com*

 ***website: www.julmerphd.com***

**Child or Adolescent Informed Consent Supplement**

Child/AdolescentPatient:

By signing below, you show that you have read and understood the policies described in my Informed Consent document you have just signed. If you have any questions as we progress with therapy, you can ask me at any time.

Minor’s Signature\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child’s privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child’s/adolescent’s treatment. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist’s professional judgment, unless otherwise noted above. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_