Heal Together Counseling
Consent to Treatment

I understand and consent for my child to receive treatment in accordance with the laws protecting confidentiality.

What to expect:
The purpose of meeting with a therapist is to identify specific goals that you would like to address so that you can be the most successful version of you. At times, this can be very difficult work and together we will work on healing and personal growth. I am committed to protecting your thoughts and feelings and the information that you share. There are times when I am bound, by law, to share certain pieces of information, these include:

- A plan to harm yourself
- A plan to harm someone else
- A report of child/elder abuse
- A court ordered subpoena

Parental Communication:
Our time together is important and your ability to trust me is key to making lasting change. For this reason, I will not be sharing specific information with your parents (unless it pertains to the list above) without your consent. There may be times when I feel that it is important to share aspects of your life with your parents and would encourage you to do so either with or without therapeutic support.

Third Party Communication:
At times, it may be important for me to speak with other adults with whom you work with. This could include school personnel, doctors, or other providers. I will not communicate specific information about your therapy sessions without yours and your parent's consent.

Parental Consent to Respect Privacy:

- I agree to refrain from requesting specific therapy information shared during sessions. I understand that I will receive periodic updates and be asked to participate in sessions as deemed appropriate. ______________________________ (initial)

- I acknowledge that while I have the right to request my minor child's record I will NOT request this record to protect my child's confidentiality. _______________________ (initial)

- I understand that I will be contacted immediately if there is a concern for imminent danger to self or others. I understand that this breach of confidentiality is at the discretion of the therapist. ________________________ (initial)

Practice Policies

- I understand that any cancellations need to be made 24-hours prior to the scheduled appointment time. Late cancellations will be charged the full session rate depending upon circumstances and at the discretion of the therapist.

- I understand that "No Show" appointments will be charged the full session rate.

- I understand that mental health records may contain sensitive information. It is the practice policy to maintain the confidentiality of these records unless subpoenaed by a judge (information may be limited to prevent harm). Any request for records outside of a subpoena will be limited to a treatment summary.

- I understand that I have a right to confidentially but that the following limitations apply: suspected child/elder abuse, threats of bodily harm towards another person, threats of bodily harm to self. If these limitations are suspected, Heal Together Counseling is required to share limited client information with agencies, law enforcement and other individuals to ensure safety of all parties.

- I understand that Heal Together Counseling will not make recommendations related to child custody.

- I understand that any recommendation letters pertaining to gender affirming treatments is at the clinical discretion of the therapist.

- I understand that any recommendation letters pertaining to service animals, emotional support animals, or other requests shall be at the clinical discretion of the therapist.

- I understand that, at times, my therapist may participate in clinical consultation regarding my case. No identifiable information will be shared. Consultation is designed to help ensure the best clinical care is received.

- I understand that participation in treatment is essential. Should I have three "late cancellation/no show" appointments and/or three cancelled appointments without rescheduling within the same week during a six-month period, I understand that Heal Together Counseling, LLC has the right to discharge me from therapy services.

Consent to Treatment Signature Page

By signing below, the parties acknowledge that they have reviewed the Consent to Treatment document for Heal Together Counseling, LLC and have had any questions about the information within the document answered.

______________________________	______________________________
Client Name	Date
______________________________	______________________________
Client Signature	Relationship to Client
______________________________	______________________________
Parent/Guardian Name	Date
______________________________	______________________________
Parent/Guardian Signature	Relationship to Client
______________________________	______________________________
Parent/Guardian Name	Date
______________________________	______________________________
Parent/Guardian Signature	Relationship to Client
______________________________	______________________________
Therapist Signature	Date