Heal Together Counseling, LLC
194A Pleasant Street, Suite 206
Concord, NH 03301
Phone: 401-584-4325
Fax: 978-616-7325

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/your child would like to address so that your child can reach their full potential. I am committed to protecting your child's thoughts and feelings and the information that they share. There are times when I am bound, by law, to share certain pieces of information, these include:

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

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

Third Party Communication:
At times, it may be important for me to speak with other providers who work with your child. This could include school personnel, doctors, or other specialists. I will not communicate specific information about therapy sessions without your 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 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 my child has 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/visitation.

- 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 if my child is more than 10 minutes late to their session, without any communication to the therapist, services may not be able to be provided.

- 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 that the highest level of clinical care is provided.

- I understand that participation in treatment is essential. Should I have three "late cancellation/no show" appointments during a six-month period Heal Together Counseling, LLC has the right to discharge my child from therapy services with referrals offered.

- I understand that any video/audio recording of therapy sessions is strictly prohibited.

- I understand that Heal Together Counseling is not responsible for my child's physical care. Parent/guardian/caregiver must remain on the premises during sessions in the event of an emergency.

- In the event of an emergency whereby Rebecca Searles or other Heal Together Counseling staff are unavailable/unable to contact clients directly, I understand that an identified proxy social worker will have access to client contact information to discuss options for services and provide families with updates. By initialing, I consent to contact information being shared with an identified proxy.

Consent To Treat Signatures

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 of Birth
_____	_____
Parent/Guardian Signature	Parent/Guardian Printed Name
_____	_____
Parent/Guardian Signature	Parent/Guardian Printed Name
_____	_____
Therapist Signature	Date