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

Walk & Talk Therapy Consent

Client Name: _____ Date of Birth: _____

I understand that it may be determined by my child's therapist at Heal Together Counseling, LLC, that walk/talk therapy is a clinically appropriate intervention to support my child's treatment plan goals. This intervention would take place outside of the Heal Together Counseling office.

By signing below, I understand and agree to the following:

- I acknowledge that my child has no medical conditions that would make walk/talk therapy physically unsafe.
- I understand that my child will be allowed to set the pace of the walk.
- I understand that this time is not focused on exercise but rather on improving mental health through the use of movement.
- I take full responsibility for my child's physical and medical well-being and any financial costs associated with their care. I understand and agree that Heal Together Counseling or any of its therapists shall not be responsible for any medical conditions, accidents or other events that may occur during walk/talk therapy.
- I understand that it is my responsibility to inform my child's therapist if a new medical condition arises that may prevent walk/talk therapy from being an option.
- I understand that while in a walk/talk therapy session, there is a chance that my child will come into contact with someone they know. My child has the right to determine if they want to share or withhold that they are in a therapy session. Therapist will follow the child's lead with regards to communication and will work to ensure that privacy and confidentiality are preserved to the best of the therapist's ability.
- I understand that if the therapist runs into someone they know, the therapist will not acknowledge that a walk/talk therapy session is occurring and will limit interactions to help persevere privacy and confidentiality.

Walk & Talk Therapy Consent Signature Page

Client Name	Date of Birth
Parent/Guardian Name	Parent/Guardian signature
Date	Therapist Signature