**Thrive Family Co.**

1152 2nd Avenue

Ladysmith, BC, V9G 1A1

Phone: (250) 924-4226

**Informed Consent for Psychological Services for**

**Minor Children**

| Child’s Full Name: | DOB: |
| --- | --- |
| Address: | |
| Email: | Phone: |
| Parent/Guardian Full Name: | DOB: |
| Address: | |
| Email: | Phone: |

**Introduction**

I, the undersigned parent/guardian, hereby provide my informed consent for my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to receive psychological services. I acknowledge that my child may benefit from therapy or counseling, and I understand the importance of actively participating in their mental health treatment.

**Purpose of Services**

The purpose of these psychological services is to address the emotional, behavioral, and psychological well-being of my child. These services may include individual therapy, psychological assessments, and other related interventions, as determined by the mental health professional.

**Confidentiality**

I understand that the mental health professional providing services to my child will strive to maintain confidentiality within the boundaries of the law. However, I acknowledge that there are legal and ethical limits to confidentiality, and the mental health professional may need to disclose information if:

* There is a risk of harm to my child or others.
* My child is involved in illegal activities.
* Court-mandated reporting is required.
* My child is unable to keep themselves safe.

**Rights and Responsibilities**

As a parent/guardian, I have the following rights and responsibilities:

**Rights:**

* To be informed about the goals and progress of my child's treatment.
* To ask questions and seek clarification regarding the treatment plan.
* To request a change in treatment approach or therapist if necessary.
* To access my child's records, subject to legal restrictions.
* To withdraw my consent for services at any time, understanding that this may impact my child's progress.

**Responsibilities:**

* To provide accurate and complete information about my child's history and current circumstances.
* To actively participate in my child's treatment, including attending sessions when necessary.
* To communicate any changes or concerns related to my child's mental health to the mental health professional.
* To adhere to the agreed-upon treatment plan and schedule.
* Fees and Payment

I understand that fees for psychological services will be discussed and agreed upon with the mental health professional. I am responsible for payment of these fees, and I acknowledge that insurance coverage, if applicable, may have limitations and requirements.

**Emergency Contact Information**

In the event of an emergency or crisis, I authorize the mental health professional to contact me or, if unavailable, the following emergency contact:

| Emergency Contact Name: | Phone: |
| --- | --- |

**Termination of Services**

I understand that the mental health professional may terminate services if they believe it is in the best interest of my child or if I fail to meet my responsibilities as outlined in this consent form.

By signing below, I acknowledge that I have read, understood, and agree to the terms and conditions outlined in this Informed Consent for Psychological Services for Minor Children. I give consent for my child to receive psychological services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Minor’s Printed Name Signature Date

**\*If child is under States legal age for mental health treatment add guardian signature below:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of parent/guardian: Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of parent/guardian: Signature Date

This consent form is valid until revoked in writing by the parent/guardian or until the completion of services as determined by the mental health professional.