Creating Connections Counseling

PERMISSION TO TREAT A MINOR CHILD:

I, being informed that my child may need mental health services, do voluntarily consent to and authorize services including psycho-education, individual and family psycho-therapy, play therapy, psychotherapy groups, social skills groups, support groups, psychological testing, and any other services that my therapist may deem necessary. I acknowledge that I have received information regarding the services described above and that I have had all my questions answered regarding the services. I acknowledge that as my child's parent/guardian and a participant in services that there are risks associated with mental health treatment for my child. I understand that as a result of treatment my child may have new thoughts, feelings, images, or moods that are negative. I understand that it is my responsibility to share any negative reaction my child has to the services provided by my therapist. I acknowledge that no guarantees have been made to me about my child as to the results of such services/ procedures.

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Parent/ Guardian Signature **Date**

PERMISSION FOR SPECIALIZED ATTACHMENT AND BONDING FAMILY THERAPY:

I, being informed that my child may need attachment-based services, do voluntarily consent to and authorize child sessions in which therapeutic holding may take place. In the process of therapeutic holding, the child or adolescent lies across the parents' lap and is held or cradled by the attachment figure. At CCC, the child never sits in a bonding position with the therapist. Physical contact that is nurturing, that provides containment and safety, and that is done with the purpose of emotionally regulating the child has proved to be effective by numerous attachment therapists. I acknowledge that I have received information regarding the services described above and that I have had all my questions answered regarding the services. I acknowledge that as my child's parent/guardian and as a participant in services that there are risks associated with mental health treatment for my child. I understand that as a result of treatment my family may go through stages of interacting differently and that my family members will experience this transition differently. I understand that it is my responsibility to share any negative reaction my family members have as result of the services provided by my therapist. I acknowledge that no guarantees have been made to me about my child as to the results of such services/ procedures.

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Parent/Guardian Signature **Date**

NOTIFICATION MY PROVIDER IS A MANDATORY REPORTER:

I acknowledge that my provider is a mandatory reporter and is required by law to report any suspicion of child physical abuse, emotional abuse, sexual abuse, neglect, failure to educate, or failure to maintain adequate health care or safety for the child. I acknowledge that my provider is required by law to report to the appropriate authority if the provider determines that the client or any member of the client family system active in treatment is a danger to themselves or others.

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Parent/Guardian Signature **Date**

Creating Connections Counseling, PLLC

AUTHORIZATION FOR ADULT MENTAL HEALTH SERVICES:

I, being informed that I may need mental health services, do voluntarily consent to and authorize services including psycho-education, individual and family psycho-therapy, support groups, psychological testing, and any other services that my therapist may deem necessary. I acknowledge that I have received information regarding the services described above and that I have had all my questions answered regarding the services. I acknowledge that as a participant in services that there are risks associated with mental health treatment. I understand that as a result of treatment I may have new thoughts, feelings, images, or moods that are negative. I understand that it is my responsibility to share any negative reaction I have to the services provided with my therapist. I acknowledge that no guarantees have been made to me as to the results of such services/ procedures.

_____

Signature **Date**

NOTIFICATION MY PROVIDER IS A MANDATORY REPORTER:

I acknowledge that my provider is a mandatory reporter and is required by law to report any suspicion of child physical abuse, emotional abuse, sexual abuse, neglect, failure to educate, or failure to maintain adequate health care or safety for the child. I acknowledge that my provider is required by law to report to the appropriate authority if the provider determines that the client or any member of the client family system active in treatment is a danger to themselves or others.

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Signature **Date**