MINORS IN MENTAL HEALTH THERAPY

1. The parent/Legal Guardian whose signature is on the Financial Agreement is ultimately responsible for prompt payment on the account. This policy applies no matter which parent schedules the appointment, brings the child, or incurs late cancelation charges. **It is important that the parent who signed the Financial Agreement fully informs the other parent as to our financial policies to avoid confusion. This is especially important when the parents are divorced or not living together. Whoever signs the Financial Agreement is responsible for any and all billable charges on the child's account. Disputes on who scheduled the child's appointment or requested the services are to be resolved between the parents and not with our office.**

2. In order for children to participate and speak freely in therapy they need to be assured of their rights to confidentially. The child needs to know what information will be kept between the child and therapist and what information will be shared with parents and other parties.

3. When a child makes a comment or shows other signs that indicate a suicide risk may be present a parent is informed immediately.

4. When a child indicates that they are intending to physically harm another person the parents and the other person are promptly notified.

5. When a child makes a comment, or shows signs, that physical or sexual abuse may have taken place both the parents and Children Services are notified. Physical/sexual abuse suspicions must be reported to Children Services as stipulated by Ohio state law.

6. Parents are always informed of progress in therapy. The child's primary relationship is with their parent(s). The main purpose of mental health therapy with a child is to enhance and improve the child's life outside of the therapy session.

7. Non-custodial parents will be notified of their child(ren)'s participation in therapy. Non-custodial parents will be required to sign this form indicating that both parents of the child are aware of and are in agreement with the child(ren) entering mental health counseling.

By signing this form you as the parent are indicating that you understand the therapy information that will be kept confidential and the information that would be promptly shared with you. By signing you are also giving the assigned therapist your permission to provide mental health counseling to your child at Psych and Psych Services.

Name of Child(ren)_____

Assigned Therapist_____

Parent/Legal Guardian: **X**_____ Print Name_____
(Date)

Parent/Legal Guardian: **X**_____ Print Name:_____
(Date)

** **It is Psych and Psych Services Policy that minors or adults under guardianship must have permission from parents or guardians to receive mental health treatment.** **