Counselor Name______________________________

Credentials_________________________________

Licensed Counselor #_________________________
Mental Health Counselor
614 W. McGraw St. Seattle, WA 98119

Agreement for Psychotherapy with a Minor

I,______________________________, attest that I am the parent/legal guardian of _______ __________________________, and give my permission for this minor to receive services from (Name of therapist, credentials). Treatment may include individual therapy, family therapy and case management. Exclusions to the treatment are as follows:

____
____
____
____

My goals for this treatment are as follows:

____
____
____
____

These services are to be provided by (name of therapist) and may include confidential supervision and/or consultation in an effort to provide more appropriate services. Fees for treatment are payable at the time of service and are as follows:

- ❑ *50-minute session (price)*
- ❑ *75-minute session (price)*
- ❑ *Case management is billed incrementally at a rate of (price) an hour, including any necessary travel time. **These expenses are generally not covered by insurance plans and are to be paid by the individual authorizing services.***

I understand that information concerning my child/minor, is protected by strict confidentiality laws and require my written consent prior to any disclosures. I also recognize that information regarding diagnosis and treatment approach is available to me at any time.

My signature below means that I understand and agree with all of the points above and acknowledge that this document does not supersede information provided to me in the Disclosure Statement.

_______________________________ _________________________
Signature of Parent/Guardian Date

_______________________________ _________________________
Signature of Parent/Guardian Date