

SANTOS COUNSELING P.L.L.C



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CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS

*****Only needed for patients under 18 years of age*****

It is important and essential to the treatment process that Mr. Juan Santos maintain a confidential relationship with your child(ren) and/or adolescents. Although the parents/guardians have a legal right to information from therapy session, I ask that parents/guardians agree to the same confidentiality that would be offered if the client were an adult. I understand that I have the right to consent to treatment or to refuse treatment. I have the right to consent for treatment in accordance with 10A NCAC 27 D .0303 and the right to refuse treatment without threat or termination of services. Consent for treatment may be withdrawn at any time.

I/We consent for _____ to receive treatment as a client with a confidential
Child/adolescent name

therapeutic relationship with Mr. Juan B. Santos.

Per Santos Counseling PLLC guideline, please provide full contact information and have a copy of the custody order/agreement by the third session if shared custody exists. Per Santos Counseling PLLC ethical code and guidelines, we will notify you (legal guardian) and/or emergency contact if your child is in danger to themselves or someone else. Parents (legal guardian) are required to remain on premises during each session.

By signing below, you are giving permission to Santos Counseling PLLC to provide treatment to your child (minor) for mental health counseling services and agree to the statement and policies regarding minor's in the Counselor Client Agreement, HIPPA and Confidentiality.

Signature (Legal Guardian):



Date:



____ Initials