Deborah G. Kabrane, LPC

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PERMISSION FOR PSYCHOLOGICAL TREATMENT OF A MINOR CHILD

Minor's Name_____ **Birth date**_____/_____/_____ **Age**_____

I, _____ , am the legal custodian of the above named minor.

Please check one.

☐ I have full legal authority to consent to treatment of the minor without obtaining consent or approval of another person.

☐ I have joint custody of the minor pursuant to a decree that requires both my consent and the consent of another person.

I hereby authorize Deborah G. Kabrane, M.A., LPC to provide counseling to the minor stated above in connection with substance abuse , mental health and / or other personal problems. I further affirm that I have the legal authority to seek and grant permission for psychological treatment for the above-mentioned minor child. There being no legal decree or modification to my knowledge disallowing my authority to assume such responsibility.

PATIENT LITIGATION STATEMENT

Be it known that therapist generally, does not participate in any litigation, or custody dispute in which Patient, or Representative, and another individual, or entity, are parties. Therapist will make every effort to be uninvolved in any custody disputes between Patient's parents. Therapist will not voluntarily provide records or testimony unless compelled to do so.

If subpoenaed, the issuing party agrees to pay therapist $250.00 per hour to include document preparation, court summaries, depositions, court appearances, testimony, travel time and attorney consultations, with a nonrefundable minimum retainer of $500.00. Payment of the retainer is due 72 business hours prior to the time of the scheduled court request. The fee applies for each court visit, whether or not testimony actually takes place. Issuing party also agrees to pay any attorney fees incurred by Therapist regarding your legal matter. *Please note fees are the separate responsibility of the Patient / Parent or Legal Guardian and are not reimbursable by your insurance.*

As indicated by my signature below, I hereby release, waive, discharge and covenant not to sue Deborah G. Kabrane, LPC in the event that she is compelled by a court of law or presiding judge to provide testimony or documentation that may result in an unfavorable ruling, order, motion or modification, thus holding her harmless and free of any liability, damages, or costs, including but not limited to court costs and attorney fees.

CONFIDENTIALITY AND THE TREATMENT OF MINORS:

Be it known that if your child is under eighteen years of age the law may provide you the right to examine your child's treatment records. When I treat children under the age of 12, it is my policy to share all clinical information with the parents / legal guardians. For clients between the ages of 12 and 18 is it vital to establish a safe and trusting environment for your youth to explore his / her thoughts and feelings. Therefore, it is generally my policy, with your signed consent below to provide general information about our individual work together, unless your child is suicidal, homicidal or engaging in "high risk" behaviors that may cause harm to self or others. In these instances, I will immediately notify you of my concern. General information may include your adolescent's treatment progress, attendance and participation at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete with a written request from you to do so. Before giving parents any additional information, I will discuss the matter with the minor child, if possible, and do my best to handle any objections or concerns.

X_____ _____/_____/_____

Parent or Legal Guardian Date

_____ _____/_____/_____

Witness Date