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Consent for Treatment of a Minor Agreement

In the psychotherapeutic treatment of children and unemancipated minors, the parents, legal guardians, or custodial parents are typically the holder of privilege, subject to the limitations described in the informed Consent for Treatment Agreement for Adults that you have received, read, understood and signed. This means that the parents, legal guardians, or custodial parents can have access to information concerning the treatment of a minor.

However, there are some exceptions to the parents' or guardians' right to access information about a child's treatment. For example, if a child approaches a therapist by herself/himself/themselves with problems of pregnancy, drug abuse or child abuse, the therapist is the holder of privilege.

Additionally, when a child approaches a therapist by himself/herself/themselves and it is clearly in the best interest of the child for the therapist not to reveal the information to the parents or guardians, including the fact that the child is in treatment, then the therapist is the holder of privilege.

In order for treatment of a child or adolescent to be effective, it is important that the child feel safe enough to talk freely without worrying that the parents will tell others what he/she/they say(s). Therefore, when communicating with parents or guardians, therapists of children and adolescents often make a general report of progress or of what generally transpires during sessions, rather than disclosing specific details of meetings.

Consent for Your Child to Receive Treatment

By signing this form, you are agreeing to the following:

I have reviewed the information in this Consent for Treatment of a Minor Agreement. I have discussed this Agreement form and the contents here with Nancy Vierra, MFT, and I have had my questions answered by her to my satisfaction. I fully understand this Consent for Treatment of a Minor Agreement. I agree to abide by the contents and terms of this agreement. I certify that I am the parent, legal guardian, or custodial parent and I authorize evaluation and treatment of my child by Nancy Vierra, MFT.

Name of Minor (please print)

Date of Birth

Name of Parent/Legal Guardian/Custodial Parent (please print)

Signature of Parent/Legal Guardian/Custodial Parent

Date