**CONSENT FOR SPECIAL CIRCUMSTANCES**

**Therapist’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CHILDREN AND ADOLESCENTS AGES 15 AND UNDER:**

**At these ages, child clients are considered dependents and confidentiality belongs to the legal parent/guardian(s). It should be explained to a child that there is a difference between privacy and confidentiality; therefore, a child can expect that their communications be kept private unless it is the judgment of the therapist that parents need to be brought in on a particular issue. Examples might include (but are not limited to), safety concerns, medical issues, family dynamics, or other situations in which the parent may be needed as a resource.**

**CHILDREN OF DIVORCED/SEPARATED PARENTS:**

**Although these situations can be difficult and delicate, there are certain legal and ethical guidelines that I follow:**

* **CONSENT FOR TREATMENT MUST BE OBTAINED FROM BOTH PARENTS unless sole legal custody is documented. I will require that a copy of this document be kept in my file.**
* **Unless sole custody is established, both parents have a right to communicate with me regarding treatment issues. I have the right to communicate with either/both parents regarding treatment issues based on my clinical judgment. All written communications will be copied to both parents.**
* **Because the child is the client, it is my job to work as an advocate for the welfare of the child. Unresolved marital conflicts may require treatment in another therapeutic setting.**

**I understand or have discussed any questions:**

**Parent signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT FOR SPECIAL CIRCUMSTANCES**

**Therapist’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADOLESCENTS AGES 16, 17, 18 YEARS OLD and SOME COLLEGE STUDENTS:**

**At these ages in SC, confidentiality belongs to the client. I am aware that in most cases, children may still be legally dependent, living at home, and those parents are likely paying for therapy; nonetheless, this is the law. I MUST HAVE WRITTEN CONSENT OF THE CLIENT TO COMMUNICATE WITH PARENTS.**

**It is my general philosophy to facilitate communication between adolescents and their families and will attempt to bring parents’ concerns into the therapy. When I deem it clinically important, periodic family meetings will be requested.**

**If an adolescent client is engaged in risky behavior, I operate under the same principles that apply to adult clients, working toward therapeutic remediation of the problem. The dangerousness of the behavior is a clinical judgment and in circumstances in which an adolescent refuses to cooperate with treatment recommendations, it may be necessary to terminate treatment.**

**Information received from parents via phone calls, voice mail, and/or written communication will not generally be kept secret as this impedes the therapeutic process and relationship.**

**I understand or have discussed any questions.**

**Client signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**