

**PERMISSION FOR PSYCHOLOGICAL TREATMENT OF A MINOR CHILD**

CONFIDENTIALITY AND THE TREATMENT OF MINORS: If your child is under eighteen years of age, please be aware that 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 or legal guardians. For clients between the ages of 12 and 18, it is my policy, with your signed consent, to only provide general information about our individual work together, unless your child is suicidal or homicidal or engaging in “high risk” behaviors that may cause harm. In these instances, I will immediately notify you of my concern. General information may include your adolescent’s treatment progress and his/her 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 child, if possible, and do my best to handle any objections he/she may have.

PATIENT LITIGATION & COURT FEES: 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 efforts 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, are not reimbursable by your insurance. As indicated by my signature below, I hereby release, waive, discharge and covenant not to sue Andee Chafin Gay, 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.**

**X** \_\_\_\_\_ **Signature Here** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **Today's Date**

Minor’s Name: \_\_\_\_\_, Birth date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_

Minor’s Name: \_\_\_\_\_, Birth date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_

Minor’s Name: \_\_\_\_\_, Birth date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_

**SIGN HERE IF BOTH BIOLOGICAL PARENTS ARE LEGALLY MARRIED OR DIVORCED WITH JOINT LEGAL CUSTODY**

We, (Mother’s Signature) \_\_\_\_\_ Date: \_\_\_\_\_  
(Father’s Signature) \_\_\_\_\_ Date: \_\_\_\_\_

affirm that we have the legal authority to seek and grant permission for psychological treatment for the above-mentioned minor child(ren).

**SIGN HERE IF YOU ARE DIVORCED AND YOU ARE THE SOLE LEGAL CUSTODIAL PARENT**

That is by legal decree, you have the SOLE AND EXCLUSIVE LEGAL RIGHT to seek and consent to medical and psychological treatment for the above-mentioned minor child (ren).

I, affirm that I am the legal custodial parent / managing conservator and have the sole and exclusive legal authority to seek and grant permission for psychological treatment for the above-mentioned minor child(ren). There being no legal decree or modification disallowing my authority to assume such responsibility.

(Legal Custodial Parent Signature) \_\_\_\_\_ Date: \_\_\_\_\_

Andee Chafin Gay, LPC, License Number 3815 \_\_\_\_\_ Date \_\_\_\_\_