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Parent Informed Consent for Counseling Services

Childs Name _____Date of Birth_____

I as the parent/ legal guardian am fully aware of the circumstances of my child's participation in counseling services and I give Trinity Christian Counseling my informed consent to provide these services.

Information will be treated confidentially unless there is reason to suspect the occurrence of child abuse or neglect; where there is a clear threat to do serious bodily harm to self and/or others; or where mandated under court order.

I understand that the successful termination of treatment is determined when the counselor and the client agree that the goals of treatment are achieved. However, I also understand that I am free to discontinue treatment on my own at any time.

After 90 days of inactivity in sessions, a client will be termed inactive.

Print Parent Name_____

Parent Signature_____Date_____

Please list the names of those who information can be released to:

Name	Relationship to child	Date of Birth

David Brown DCE, LPC, NCC
Kristin Hardy DCE, LPC, NCC
Zhela Bennett, LPC
Dan Burke MA, LLP
Amy Prosch, LMSW