Boston Evening Therapy Associates, LLC
7 Kent Street
Brookline, MA 02445
(617) 738-1480
www.bostoneveningtherapy.com

Child Services Informed Consent

Child (Client's Name): _____ DOB: _____
Address: _____

Parent/Guardian: _____ Phone: _____
Address: _____
☐Physical Custody ☐Legal Custody

Parent/Guardian: _____ Phone: _____
Address: _____
☐Physical Custody ☐Legal Custody

School: _____
Grade: _____
Primary Care Physician: _____
Address: _____ Phone: _____

Thank you for contacting Boston Evening Therapy Associates, LLC regarding your child's needs. We very much look forward to working with your child and family. An essential component to successful treatment is ongoing communication between parents and the clinician. The following are guidelines that will make our work together effective and meaningful. The purpose of my work with your child is to help them overcome their present challenges and reach their highest potential.

Your child is my client and is afforded particular legal rights as mandated by my profession's ethical code.

Confidentiality

Due to my professional ethical code, I am unable to discuss your child's sessions with anyone within the following exceptions:

1) Your child plans to hurt themselves or someone else. These actions may include: My notifying a potential victim, contacting the police, or seeking hospitalization for my client.
2) I am mandated by a court of law to testify regarding a child custody

dispute or a case in which your mental health is at issue.
3) As a professional with high ethical standards I occasionally consult with a supervisor to ensure the best quality of care for my clients. In the event that a relevant part of work together comes up, I will keep your child's identity confidential.

Please Note: Only the court can waive your child's privilege and/or make a determination as to the release of confidential psychotherapy records. Probate Courts can and do appoint special guardians ad litem to decide this question for a child.

In the event where parents are legally separated or divorced, legal and/or physical custody of the child (my client) is essential to determine. In the event of a shared custody agreement where both parents have legal and physical custody of the child, we will schedule appointments on a mutually agreed upon time, place, and date. Additionally, we will agree on which parent (or both) will be financially responsible for my fee.
In the event that you are late picking your child up from a session, a fee of $20.00 per every 5-minute period of time that your child is waiting will be charged, and a cash or check payment will be expected at that time.

Communication
I do not communicate about my client's treatment via any electronic means. I accept emails and texts regarding appointments and cancellations only. In the event that you would like to communicate with me regarding your child's clinical treatment I welcome you to schedule an appointment with me at my rate to be paid in cash or by check. Insurance does not cover these sessions.

I look forward to working with you on behalf of your child's positive development and progress.

_____

Signature: Parent/Guardian Date

_____

Signature: Parent/Guardian Date

Updated: 8/26/13