***Humano Family Counseling, Inc***. ***(HFC)*** requires this form to be signed and on file for all minor clients and parents/legal guardian understand the following.

|  |
| --- |
|  **Minors** |
| For clients who are under 18 years of age ***HFC*** requires the consent for treatment is signed by **BOTH** parents prior to providing service. For minors if any question exists regarding the authority of a Representative to give consent for psychotherapy, ***HFC***, will require the Parent(s) or Guardian(s), submit supporting legal documentation, such as a custody order, etc. Also, it is important to know how Confidentiality & Privilege apply to minors prior to consenting. |
| **Confidentiality & Minors** |
| The same confidentiality exists between child & psychotherapist, as with adult. It is important as parents/guardians of a minor in psychotherapy you understand you will not be privy to detailed discussions between therapists and minor. However, from time to time therapist will give progress reports on the therapeutic process.  |
| **Psychotherapist-Minor Client Privilege** |
| When a client is a minor child, the holder of the psychotherapist-client privilege is either the minor, a court appointed guardian, or minor’s counsel. Parents typically do NOT have the authority to waive the psychotherapist-client privilege for their minor children, unless given such authority by a court of law.  |

***Please, read carefully and initial the one that applies to your relationship with child/minor on page 2.***

|  |  |  |
| --- | --- | --- |
| **Both Legal Parents/Guardians** | **Divorce/Custody or Legal Issues** | **Missing or Deceased Parent** |
| * Both legal parents and/or guardians agree to the treatment and providing of mental health services for their child/minor and will indicate their consent below.
* Biological or legally adopted parents are currently separated or going through the divorce process, both parents are required to sign the Client Information & Consent Form before the child can be treated.
 | * Who is the Managing Conservator?
* Have any step-patent been given authority by the court to consent for treatment of the minor? ☐Yes ☐No
* Is there an official certified divorce decree or legal custody order indicating only one parent is legally permitted to determine and decide on the mental health treatment of the minor without the consent of the other parent, please provide our office with a copy of the Court Order/Divorce Decree in its entirety.
 | * Parent presenting the child for treatment has NO access to the other parent due to the following reasons (death, in prison, missing, has left and made no contact, etc.) and therefore acknowledges they are the sole primary caretaker of the child for mental health treatment and will bare all responsibility for such consent.
 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |
| --- | --- |
|  |  |
| **Client’s Name** | **Date of Birth** |

|  |
| --- |
| **Note*:*** *Please check the one that applies: (***F***)ather, (***M***)other, or (***G***)uardian. Mark (****N/A****) if only one parent/guardian required.*  |
| **First Name** | **Middle Name** | **Last Name** | **Parent or Guardian** |
|  | ☐ F [ ] M ☐ G |
|  | ☐ F ☐ M ☐ G ☐N/A |
| **Initial**  | **Initial** |  **Both Legal Parents/Guardians Consent to Treatment** |
| * We affirm we are the legal parents and have the authority to make healthcare decisions for the above referenced child/minor.
* We agree that we are the Legal Guardians or Managing Conservator of the above-named client and have provided all available information regarding custody agreements applying to the above-named client.
 |
| **Initial** |  **Divorce, Custody or Legal Issues** |
| * I affirm I have the authority to make healthcare decisions for above referenced child/minor.
* I understand it is ultimately my responsibility to make sure I am following all legal conditions set forth by my divorce decree, separation agreement, etc.
* I agree, I am the Legal Guardian or Managing Conservator of the above-named minor/child and have provided all available information regarding custody agreements applying to the above-named child/minor.
 |
| **Initial** |  **Missing or Deceased Parent** |
| * I hereby swear and affirm under any applicable perjury laws that there is no legal divorce decree, custody order, or separation agreement that restricts or limits me from making any or all decision in regard to my child’s mental health treatment. I further acknowledge ***Humano Family Counseling, Inc***. has asked and attempted to collect any and all such documents from me.
 |
| **Applies to All** |
| * I am aware that all custodial parents and legal guardians **must** give consent before treatment begins. I understand and agree that any breach of these agreements may result in the termination of treatment services with ***Humano Family Counseling, Inc.***
* I give consent to ***HUMANO Family Counseling, Inc.,*** to provide counseling to the above-named child/minor.
 |
| ***I am voluntarily signing this agreement.*** | ***I am voluntarily signing this agreement.*** ☐**N/A** |
| 🖌 |  | 🖌 |  |
| **Signature** | **Date** | **Signature** | **Date** |
|  |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Form/Information** | **Given** | **Declined** | **Date** | **Initial** |
| **Consent for Treatment of a Child/Minor** | **X** |  |  | ***Sent via email*** |
| **Witnessed by:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **M. Lourdes Tapia, MA, LMFT** |  | 🖌 ***MLTapia*** |  |  |
| **Print Witness/Therapist’s Name** |  | **Witness/Therapist’s Signature** |  | **Date** |

 |

 **INABILITY TO OBTAIN ACKNOWLEDGEMENT** (*OFFICE USE ONLY*)To be completed only if signature is not obtained. Please check box which applies:[ ] Parent/Legal Guardian refused to sign ☐Describe Good Faith effort to obtain acknowledgement, & the reason(s) why it was not obtained \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Albina Lopez, LMFT** |  | 🖌 |  |  |
| **Print Witness/Therapist’s Name** |  | **Witness/Therapist’s Signature** |  | **Date** |

***Confidential Information | See California W&I Code 5328*** |