DEBRA K. SOWALD, PSY.D.
PSYCHOLOGIST
28 E RAHN RD SUITE 105
KETTERING, OH 45429

CONSENT TO TREAT A CHILD/ADOLESCENT

Part I: In order for us to treat a minor child (under 18 years of age) we must have the written consent of the child's parent(s) or legal guardian(s). Please indicate your consent for us to treat your child by signing the following statement:

I, _____, state that I have the legal right to authorize DEBRA K. SOWALD, PSY.D. to provide mental health services to _____ (DOB:_____) and do herewith authorize said services.

_____

Signature **Date**

Part II: As a rule, parents or legal guardians have a right to complete access to all information concerning the adolescent or child involved in therapy with us. However, our experience suggests that in order for many child and/or adolescent clients to feel comfortable in therapy, it is beneficial to offer them the opportunity to talk with the therapist and to know that what they tell the therapist will not get back to their parents (except in cases of imminent danger to the client or others, or where the therapist considers the information to be so serious that the parents' ultimate responsibility for the child's welfare dictates that the parents be kept informed).

We ask that you consider this issue in the therapy with your child. If you are willing to agree to this informal waiver of your right to full disclosure, we ask that you do the following:

a) indicate your agreement by signing the form below, and
b) tell your child that you have agreed to allow him/her to talk with us with a spirit of privacy, and that you will not insist that we relate all that your child tells us back to you.

_____

Signature **Date**

_____

Signature **Date**