SIOUXLAND CHILD & ADOLESCENT THERAPY SERVICES, LLC

3700 S. Kiwanis Ave. Suite 4
Sioux Falls, SD 57105
(605) 271-7117
Email: info@siouxlandtherapy.com
Website: siouxlandtherapy.com

INFORMED CONSENT FOR MINORS

Client Name: _____ Date of Birth: _____ Age: _____

Legal Guardian Name: _____ Relationship to Client: _____

Psychotherapy with people of any age relies on the client's confidence that what is shared with the therapist is private and confidential. While parents and guardians have a right to know general information about how therapy with their child is progressing, in signing this form you waive the right to know the private details of the child's therapy, or to have access to the confidential therapy records of the child. A general summary can be provided at any time upon request.

Information provided within the counseling relationship will be strictly confidential. However, exceptions to confidentiality include the following:

1. If there is a danger to self or others. Confidentiality may be broken in order to protect self or other from harm.

2. Suspected cases of child abuse or neglect; suspected cases of abuse or neglect of an elder or an adult who is disabled. By law, information suggesting possible abuse or neglect must be reported to law enforcement, State's Attorney, or the Department of Social Services.

3. Information regarding diagnosis, treatment plan, etc. will be provided to insurance companies unless otherwise specified.

4. In instances of delinquent accounts, billing information will be provided to a third party for collection purposes. This will only take place after a final notice has been issued by Siouxland Child & Adolescent Therapy Services and no response has been received within the allowed time frame.

5. In instances where the court shall order the disclosure of otherwise privileged information.

6. In some instances it is helpful to consult with another Siouxland Child & Adolescent Therapy Services, LLC therapist regarding the treatment of a client. Please initial below regarding the possible consultation of minor's treatment.
   - ❒ I give permission for consultation of treatment
   - ❒ I do **not** give permission for consultation of treatment.

By signing this form, I understand and agree to the above information. I also confirm that I am the legal guardian for the above named minor.

_____ _____
Legal Guardian Signature Date

_____ _____
Siouxland Child & Adolescent Therapy Services, LLC Witness Signature Date