Clarity Counseling Connections

1016 E. Locust Street * Emmett, ID. 83617 * Office (208) 918-0054 * Fax (844) 696-1471

Agreement by Parent/Guardian for Counseling with a Minor

I, _____, the rightful parent/legal guardian of

_____, give my permission for this minor to receive the following

counseling services from Clarity Counseling Connections, Inc. as represented by_____.

The policies concerning the 24-hour cancellation notice and the missed appointment fee have been explained to me. I have been told about the risks and benefits of receiving these services and the risks and benefits of *not* receiving these services, for both this minor and his or her family.

Confidentiality: I understand that, under Idaho law, minors do not have a legal right to confidentiality. I also understand that confidentiality is important for this minor to feel safe in the therapeutic relationship. I therefore agree to work with this counselor so as to achieve a level of confidentiality that is necessary for this minor's therapeutic progress.

I understand that Clarity Counseling Connections, Inc. abides by the ethical codes established by the American Counseling Association, the American Association for Marriage and Family Therapy as well as the rules and statues governing the practice of counseling in the State of Idaho. These ethical codes and legal statues require counselors to report to responsible persons or state agencies when clients indicate any of the following situations:

- ☐ **That the client intends to harm self**
- ☐ **That the client intends to harm someone else**
- ☐ **Information as to direct involvement in child abuse or neglect**
- ☐ **Information as to direct involvement in abuse of the elderly.**

I understand that the counselor will keep me apprised of this minor's progress and that this counselor is willing to meet with me to discuss any concerns and or questions that I have. Progress in this minor's treatment will be reviewed on or about this date: _____ and on a regular basis after that.

Videotaping: I give my permission for the counselor to **videotape** the sessions with this minor for personal review, supervision, and limited educational purposes. All who may view these videotapes are bound by the legal framework of privacy and confidentiality. I understand that any information in these recordings that could identify myself or this minor in any way will not be published or given out without my written consent. I understand that all video recordings of these sessions will be destroyed at or before the conclusion of counseling

.

My signature below means that I understand and agree with all of the points above:

_____

Signature of parent/guardian Date

_____

Signature of minor Date

I, the counselor, have discussed the issues above with the minor client's parent or guardian. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent to the minor client's treatment.

_____ _____

Signature of counselor Date

Client Copy ☐
File Copy ☐