WELLNESS
PSYCHOLOGICAL SERVICES

# Informed Consent for Minors

I, _____,hereby give consent to Wellness Psychological Services, PLLC
(Name of consenting parent/legal guardian)

to provide psychological services to my minor child,_____.
(Minor's name & date of birth)

These psychological services may include, but are not limited to: assessment, individual psychotherapy, family counseling, group therapy and consultation.

**Confidentiality:** I understand that psychological services are confidential and may not be revealed to anyone without written permission except where disclosure is required by law under the following circumstances: (1) knowledge or reasonable suspicion of harm to self or others, (2) knowledge or reasonable suspicion of child or elder abuse, and (3) if a court order demands a release of information regarding my case.

**Electronic Communication:** Clients are welcome to email regarding scheduling and for brief follow up messages. However, please understand that we cannot guarantee confidentiality to be 100% protected via electronic communication. Please avoid sharing any sensitive information via email. Confidentiality is also not 100% guaranteed with text messages. Email or text messages are not an appropriate form of communication for crises, please see the emergency procedure below.

Psychological services are intended to be beneficial in the improvement of mental health concerns; however none of these benefits are guaranteed. You or the minor patient may disagree with the opinions offered to you and emotional distress may result from sensitive matters which are addressed during the course of treatment. Alternative referrals to another health care provider will be given if requested.

**Emergency Procedure:** Wellness Psychological Services, PLLC only provides outpatient mental health services and does not offer 24-hour emergency coverage. The office hours are Monday-Thursday 9:00am to 6:00pm. In the event of a behavioral health or medical emergency, you may call the Crisis Center of Tampa Bay at 813-264-1234. dial 911, contact your primary care physician or go to the nearest emergency room.

**Discharge:** I am aware that if the minor patient prematurely discontinues treatment without informing Wellness Psychological Services, PLLC then an administrative discharge will automatically occur 45 days after the last psychotherapy session. If this occurs I am also aware that I can contact the office to reopen the minor patient's file and resume treatment if desired.

By signing below, I confirm that I have read this form in its entirety, or it was read to me, and I understood the information provided. I have no additional questions and I have clarified anything with which I disagree. I agree that my consent is voluntary and can be revoked, in writing, at any time.

Parent/Legal Guardian's Signature: _____ Date: _____

Parent/Guardian Printed Name: _____Relationship to minor: _____