Sally Markley, LPC
Counseling Services

4737 E. Camp Lowell Dr.
520-903-8877

Consent for Treatment (Minor) Name: DOB: .

I understand that I will be engaging in psychotherapy with Sally Markley, LPC ATR. The purpose of this treatment is so that I feel better or resolve specific life or adjustment problems that have caused me to seek assistance or have caused my parent to seek assistance on my behalf. The primary procedures used by Sally are “talk” therapy and art therapy, which is the utilization of the creative process of art making to improve and enhance my physical, mental, and/or emotional well-being. I understand that she may also provide general education about mental health conditions or coping strategies. She may also assign “homework” for me to do in between sessions. The potential benefit of treatment is that I will feel better about my life, learn to manage stress, experience relief from painful emotions, or resolve problematic issues. I understand that a “cure” is not guaranteed and that it is possible that as I talk about some things, I may even feel worse. I may experience emotions more intensely as I talk about things that are upsetting, or I may notice more conflict in relationships as I make changes. I also understand that psychotherapy will be more successful if I am open and honest with Sally.

I understand that all information I share will be kept confidential, but that this confidentiality is not absolute. In the case of medical emergency, child/elder abuse or neglect, suicidal or homicidal intent, or under court order, clinical information may be released. Also, if my treatment is paid for by an insurance company, Sally will release clinical information to my insurer, but only what is required for billing. I further understand that Sally, my parent, and I will discuss and agree upon the extent to which information I provide to Sally is shared with my parent.

I understand that Sally may discuss my case with a consultation group or with an expert practice consultant and if she does so identifying information is kept confidential to the extent necessary. Also, from time to time, emergency coverage may be provided by colleagues of Sally and when this occurs she may disclose certain information as necessary to ensure appropriate coverage for me.

I understand that legally my parents can receive a copy of my records or have a copy of my records provided to another person by completing a Release of Information form.

I understand that both my parent and I have the right to participate in treatment decisions and that Sally and I will together develop and periodically review and revise a treatment plan which will identify goals for treatment as well as the means of achieving those goals. I understand that my parent has consented to my treatment and has the right to refuse any recommended treatment or to withdraw consent to treatment at any time with no consequences. I also understand that if I wish to withdraw my consent to treatment Sally will facilitate a meeting with my parent during which we will discuss my desire.

I understand that my parents are responsible for paying Sally and that except in the case of illness or emergency there will be a full charge for missed appointments which are cancelled with less than 24 hours notice.

I have read the above information and consent for treatment.

Signature of Minor:_____ Date:_____

Witness:_____ Date:_____