

**PARENTAL/GUARDIAN CONSENT FORM**  
**CHICAGO CHRISTIAN COUNSELING**

**INFORMED CONSENT TO TREAT**

**ATTENDING PARENT/GUARDIAN:**

I understand that written consent is required from both parents/guardians for my child (ren)'s involvement in treatment. This is required regardless of whether my child (ren) is/are identified as the client and a case opened in his/her name, or my child (ren) attend the sessions of one parent/guardian, even when the parent/guardian is identified as the client.

By signing this form I am stipulating that I have/will obtain the consent of the other parent/guardian, or I am stipulating that it is not possible to obtain this parent/guardian's consent because this parent/guardian is either completely uninvolved in the child(ren)'s life and/or is unreachable.

However, I agree if circumstances regarding access to the other parent/guardian change I will inform my therapist and obtain written consent from the other parent/guardian.

I understand that the treatment may involve family therapy (step parents and other adults) and may also include occasional contact without my child (ren) present.

Choose Only One of the Options Below:

1. I stipulate that a good faith effort was made to obtain the consent of the other parent/guardian, but the other parent/guardian (name) \_\_\_\_\_ was not reachable and/or did not respond to efforts to reach him/her. **(Initial here)** \_\_\_\_\_
  
2. I stipulate that the consent of the other parent/guardian (name) \_\_\_\_\_ (in writing-use attached form) has been obtained or will be obtained by the second session. **(Initial here)** \_\_\_\_\_

Name of Child (if identified client): \_\_\_\_\_

Name of Child (ren) – if they may attend):

Name of Child: \_\_\_\_\_

Name of Child: \_\_\_\_\_

Name of Child: \_\_\_\_\_

Signature of Child (12 to 17 – if identified client): \_\_\_\_\_ Date: \_\_\_\_\_

I understand that children (12 and older) have confidentiality rights regarding therapy records and information disclosed in therapy. The therapist is therefore bound to keep this information confidential unless a written release is signed by the 12 and older client. Exceptions to confidentiality are stated in our Notice of Privacy Practices given during the first session. Note: Therapists encourage all children to share their concerns and difficulties with their parents/guardian.

Print Name of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

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***NON-ATTENDING PARENT/GUARDIAN:***

I consent to the treatment of my child (ren) as non-client:

Name of Child: \_\_\_\_\_

Name of Child: \_\_\_\_\_

Name of Child: \_\_\_\_\_

OR:

I understand that a record (chart) will be opened in my child's name (as the identified patient / client) \_\_\_\_\_ with sessions billed in that name.

I understand that it is recommended that both parents be involved in therapy and it is required that both parents consent in writing (see below) to the treatment of their child.

I understand that children 12 or older have confidentiality rights regarding therapy records and information disclosed in therapy. The therapist is therefore bound to keep this information confidential unless a written release is signed by a minor client who is 12 or older. Exceptions to confidentiality are stated in our Notice of Privacy Practices given during the first session. Note: Therapists encourage all children to share their concerns and difficulties with their parents/guardian.

I understand that the treatment may involve family therapy (step parents and other adults) and may also include occasional contact without my child (ren) present.

I affirm the above with my signature.

Print Name of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_