

Molli M Wilson PHD /ADOLESCENT CONSENT FOR SERVICES FORM

Communicating with your parent(s) or guardian(s):

Washington State law (RCW 71.34.530) states that minors may receive outpatient mental health treatment if they are 13 years of age or older without the consent of a parent or guardian. Information about the service provided to individuals 13 years of age and older will not be released to a parent or any other person without the minor consent. If you are under the age of 18, your parents have a right to review your record. **I cannot not keep information confidential if you have told me that you plan to harm yourself; if you have sexually abused a child two years or more younger than yourself, or if someone has sexually abused you.**

Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you. Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — **but that do not put you at risk of serious and immediate harm.**

Client Consent to Treatment: I understand that my parent will be responsible for a **NO SHOW or late cancellation fee of \$ 150.00** if I do not contact Dr. Wilson and give her 24 hour notice in the event that I cancel my appointment _____(Initials)

Signing below indicates that you have reviewed Dr. Wilson’s Office policy and understand the limits to confidentiality.

Print Client Name

• Client Signature _____ Date_____