# Megan Bearce, LMFT

I/We, _____ give my/our consent to Megan Bearce, LMFT to conduct counseling/psychotherapy with the minor client _____.

My/our relationship to the minor client is _____.

I/we were notified that the holder of the therapist-patient privilege is (child's name)_____.

I/we were also notified that all material discussed during the counseling sessions is generally confidential unless disclosure of such information is demanded by law or permitted by law, as explained in the "*Confidentiality Statement*", "*Office Policies & Therapeutic Contract*", and "*Notices of Privacy Practices*" forms that I/we have read and signed.

I/we were also notified that the minor client may have the right to authorize the release of confidential information, especially if the minor client did or could have consented to counseling/psychotherapy her/himself.

I/we were also notified that the counselor has the right to withhold confidential information from me/us if:

1.) The minor client's counselor determines that sharing confidential information with me/us would have a detrimental effect on the counselor's professional relationship with the minor client, or

2.) The minor client's counselor determines that sharing confidential information with me/us would have a detrimental effect on the minor client's psychological safety or well-being.

I/we understand that Megan Bearce, LMFT will exercise clinical judgment in disclosing any information derived in the confidential relationship with the minor client that indicates that the well being of the minor may be in danger or jeopardy. I will accept Megan Bearce's judgment in releasing and sharing such information obtained during the course of counseling/psychotherapy.

| Name | Signature of Parent/Guardian | Relationship | Date |
|---|---|---|---|
| Name | Signature of Parent/Guardian | Relationship | Date |
| Megan Bearce, LMFT | | | Date |

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