New England Center for Healthy Minds

Informed Consent for Treatment with Parents/Guardians

Divorce, Custody or Legal Issues

As a mental health treatment practice our primary focus, responsibility and goal is the treatment and well-being of our identified patients. In the case of a child as the primary patient it is essential that parents and legal guardians are not in conflict and are in fact in agreement as to decision to treat, the treatment goals, appointment times and the need to maintain patient confidentiality. The treatment process is a team approach especially in the case of a minor child. The following informed consent states that each parent, and/or any legal guardian with authority over the health care decisions of the child, will agree to these terms and communicate effectively with each other as well as with the provider to create a supportive environment for treatment and to assist our clinicians toward attempting to achieve the most positive outcome possible.

Although our responsibility to your child may require our involvement in conflicts between parents and guardians, we need your agreement that our involvement will be strictly limited to that which will benefit your child. This means, that you each agree as a condition of us treating your child that (i) you shall treat anything that is said in any individual or group treatment session as strictly confidential; (ii) you shall not attempt to gain advantage in any legal proceeding relating to the care and custody of your child from our treatment of your child; (iii) you shall not request or require us, through subpoena, summons or other means (except as otherwise ordered by a court of competent jurisdiction), to provide testimony in favor of one parent or guardian against the another in any legal proceeding relating to the care and custody of your child; and (iv) if multiple parents or guardians desire to obtain treatment information and/or testimony from any one of our clinicians relating to your child in any legal proceeding you shall each consent to the disclosure by executing one or more authorization forms we send to you and you will each share in the cost of producing such records and/or written or live testimony at our established copying charges and/or hourly rates for our clinician's time.

If there is a court appointed evaluator, and if appropriate authorization forms are signed, or a court order authorizing disclosure of treatment records is sent to us, we will disclose the requested treatment and general information about the minor but we will not make any recommendations concerning the child's custody or custody arrangements, unless otherwise ordered by a court.

I have read the above consent over carefully and understand its content and hereby agree to the terms and conditions and consent to the treatment of my child under these terms and conditions set forth above by signing below.

I_____give my permission to _____, (relationship to patient:_____) to make decisions regarding treatment interventions, scheduling appointments and cancelling appointments, if I am not physically present during any appointments.

I_____ accept the responsibility of communicating with _____after every appointment to be updated regarding any change in the treatment plan related to _____treatment.

I _____ understand that as the custodial parent of the minor child, I am responsible for any and all payments due. Any payment received from the minor child's other parent, guardian, or family member will be deducted and applied appropriately to the child's account. If the account is in default or a payment has not been made, will look to me as the sole party responsible for the financial obligations of the account.

Parent/Guardian_____Date:_____

Parent/Guardian_____Date:_____