



WESTSIDE CENTER  
for COUNSELING and THERAPY  
205 S. Minnesota Street  
Carson City, NV 89703-4269

CHILD AND ADOLESCENT  
CONSENT TO TREAT

It is very important that your child feel that therapy is a safe place where he or she can share thoughts and feelings. I do not believe that it is possible to create this safe place if your child feels that I am reporting back to you concerning things that may be shared in his or her work with me. At the same time, I recognize parents' natural concern for their child's well-being and progress in treatment.

Therefore, you can expect that I will provide you with general updates regarding your child's progress any time you wish, but I will not inform you of any specifics that your child may share with me in our sessions. This includes behaviors about which many parents would be concerned (i.e. stealing, skipping school, drug use, lying).

You should know, however, that if your child informs me of any behavior or events that pose an imminent danger of severe physical harm to themselves or others (i.e. victim of severe bullying, drunk driving, suicidal statements), I will inform you as quickly as possible.

Your signature below indicates that you accept the above statements and are willing to allow me and your child to determine what you are told about the content of therapy sessions.

You also agree that therapy will be most beneficial if your child is allowed to have a confidential relationship with me. You understand that I will inform you if your child is in imminent, severe, physical danger and agree to allow me to determine when it is appropriate to inform you about the content of your child's sessions.

If you have any questions regarding my policy in this matter, please feel free to ask.

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(Parent or Guardian - Signature indicates acceptance of minor holding the privilege)

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(Date signed)