**Statement of Informed Consent with Minors (under the age of 18) for Play Therapy**

I, (printed name of parent/legal guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

give consent for (printed name of client/minor child) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

age \_\_\_\_\_\_\_\_\_, (date of birth) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to receive counseling services and treatment from Suzanne Davis, LPC (Virginia), RPT-S™ (Registered Play Therapist-Supervisor™) (counselor) at Davis Counseling & Play Therapy Center, PLLC.

**Potential Risk and Benefits of Play Therapy:**

In play therapy, children explore and discuss issues through their play and their words. Sometimes symptoms worsen before they improve as you and your child work through this process. Parents and children may at times feel uncomfortable levels of sadness, anxiety, guilt, frustration, helplessness, and other negative feelings as part of the healing process. Children often express this through increasing their problematic behavior. This is seen as part of the process of moving toward health. We will discuss these occurrences in parent consultation sessions.

Potential benefits of play therapy include a decrease in problem and distressing symptoms, greater self-awareness and verbalization of feelings, increased understanding of life situations, increased skills in coping and self-regulation, and improvement in relationships.

I understand this therapeutic relationship is voluntary and there are certain risks involved, such as the sharing of personal information about my child and/or his/her family. I understand that I or my child may discontinue treatment at any time; however, there might be risks involved in discontinuing treatment early.

\_\_\_\_\_\_\_\_\_ (Initials) The scope and nature of this treatment has been explained to me and I understand that there are no guarantees for treatment outcomes. I agree to hold harmless and indemnify the counselor and/or her staff from any damages, suits, claims, or liabilities arising from this therapeutic relationship.

\_\_\_\_\_\_\_\_\_ (Initials) I understand that my participation in my child’s therapeutic process (e.g., parent consultation sessions) are a critical part of my child/adolescent’s counseling experience at Davis Counseling & Play Therapy Center PLLC. I understand that my involvement in the parent consultation sessions is treated as a team and collaborative approach between myself and the counselor where the counselor provides, but not limited to, parenting skills/strategies to increase understanding, promote child well-being, improve communication and connection in the parent-child relationships, and psychoeducation. I understand that all parent consultation sessions are subject to the same confidential guidelines and requirements that are noted by applicable state and federal laws.

**Confidentiality:**

Everything we talk about in our parent consultation sessions and your child’s play therapy sessions are confidential. The session notes (or progress notes/medical records) and other paperwork regarding our work together on behalf of your child are also confidential and part of the clinical file. However, the Commonwealth of Virginia laws requires certain exceptions: If I learn of abuse/neglect of children and/or the elderly; if you (or your child) is a danger to self or others; if you request (in writing) that I release information/records; or if I receive a court order or subpoena to release information and/or records.

I cannot ensure the confidentiality of any form of communication through electronic media, including email and text messages. You are advised that such communication has the potential to be seen by others, including internet providers. I am ethically and legally obligated to maintain written documentation of each time we meet, talk on the phone, or correspond via electronic communication such as email. These records include a brief summary of the telephone conversation and printed copies of emails. Therefore, I request you *not communicate personal information by text or email*. A judge can subpoena your records for various reasons, and if this happens, I must comply. *If, however, you prefer to communicate via email* ***only*** *regarding appointments, I will do so.* Please initial that you understand the risks involved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Communication through the TheraNest Client Portal of my electronic health records program/platform are confidential. This is my preferred form of communication. These interactions automatically become part of your child’s clinical file.

\_\_\_\_\_\_\_\_\_ (Initials) I understand that confidentiality will be maintained at all times within legal requirements of the Commonwealth of Virginia and by federal law as noted in the Health Insurance Portability and Accountability Act (HIPAA),and ethical guidelines according to the American Counseling Association Code of Ethics and the Association for Play Therapy Best Practices*.*

\_\_\_\_\_\_\_\_\_ (Initials) ***I understand that confidentiality will not be maintained if my child threatens or gives reason to believe that he/she will harm themselves or others. In addition, the Commonwealth of Virginia laws requires that if the counselor suspects or has knowledge of any form of sexual or physical abuse of a child, it must be reported immediately to the proper authorities.*** If client(s) is(are) involved in family and/or marital counseling, it is encouraged that each participant maintain a “no secrets” policy, meaning that issues be addressed openly and honestly during the sessions.

In certain cases, parents do have a right to access his/her/their child’s medical records. However, it is the policy of this counselor to maintain confidentially with the child, except in the cases outlined above. The counselor will periodically keep the parents informed of the general progress of his/her/their child in parent consultation sessions, but will not give details of what occurs or is said in your child’s play therapy sessions. Generally, we will discuss play patterns and themes that occurs in your child’s play therapy sessions in parent consultation sessions by providing you with helpful and meaningful feedback to apply in the parent-child relationship. If there is information that the counselor feels might be beneficial for the child to share with the parent(s), the counselor will work with that child on how to appropriately share that information with the parent(s), including possible joint sessions with the parent(s) or family sessions.

\_\_\_\_\_\_\_\_\_ (Initials) It is the policy of this counselor that when counseling minors (clients under the age of 18), that ***the parent or legal guardian must remain in the building (e.g., waiting area) during the counseling session*.** Confidentiality is a very important part of counseling. However, a child’s or adolescent’s safety is just as important. If for any reason you feel uncomfortable with your child or adolescent meeting alone with the counselor, please make this known to the counselor so that other arrangements or referral to another counselor can be made.

**Privacy of Information (HIPAA):**

\_\_\_\_\_\_\_\_\_ (Initials) I acknowledge that I have been given a copy of the counselor’s *Health Insurance Portability and Accountability Act (HIPAA) Patient Notification of Privacy Rights* which describes how records and information about my treatment will be handled and outlines client rights and counselor duties in the professional counseling relationship.

**Credentials and Supervision:**

The counselor is licensed by the Commonwealth of Virginia as a Licensed Professional Counselor through the Virginia Board of Counseling and is a Registered Play Therapist-Supervisor™ through the Association for Play Therapy.

\_\_\_\_\_\_\_\_\_ (Initials) The credentials and qualifications of the counselor have been explained to me.

I understand that the counselor will, on occasion, participate in clinical supervision and/or clinical consultation (including peer consultation) with other counseling professionals. Cases will be discussed with other counseling professionals solely for the purpose of gaining additional perspective, input and treatment direction. Confidentiality will be maintained in this supervision and/or consultation, and the names of clients will not be used or disclosed.

**Fees:**

\_\_\_\_\_\_\_\_\_ (Initials) I understand the fees involved in this treatment and that payment is expected at the time of the counseling session, unless other arrangements have been made and agreed upon with and by the counselor. I also understand that failure to pay the expected fee could terminate counseling services. The current session fee is $100 per session (including the intake session, individual play therapy session, parent consultation session, and family session). Additional fees are outlined in the *Therapy Consent, Policies & Agreement* and the *Good Faith Estimate for Health Care Items and Services* that have been explained and provided to me.

**Sessions:**

Individual play therapy sessions are typically once a week for 50-60 minutes per session. Parent consultation sessions are typically once per month or after your child’s third play therapy session for 50-60 minutes. Family sessions with the minor client present are typically 60-75 minutes. I understand that appointments should be kept and that I should arrive on time for scheduled appointments. If the client is late for the session, the session time will be based on the allotted time for the scheduled session. The counselor reserves the right to terminate the counseling relationship if more than three consecutive sessions are missed without proper notification.

\_\_\_\_\_\_\_\_(Initials) ***If the client is more than 15 minutes late for a scheduled appointment, the appointment will be considered as a “no show” and will need to be rescheduled.* *“No shows” for appointments are subject to being charged a $50 no show/late cancellation fee.* *Cancellations need to be made 24 hours prior to scheduled appointments, except in the case of family or medical emergencies.***

**Complaints:**

If you have a complaint about my services, I hope that you will bring this up with me and make every attempt to work through the issue. However, if this does not work, you have the right to make a formal complaint to my licensing board: Virginia Department of Health Professions Board of Counseling, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233-1463, or by telephone at 1-800-533-1560. The Virginia Department of Health Professions Board of Counseling website can be located at https://www.dhp.virginia.gov/Boards/Counseling/.

**Emergency Procedures:**

In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255 or the Crisis Hotline at 627-5433 or the local Crisis Hotline (Chesapeake City Crisis Care Emergency Line) at 757-455-0368. If either you or someone else is in danger of being harmed, dial 9-1-1 or please contact your local emergency services crisis line for additional assistance or please go to the nearest hospital for immediate assistance.

Also, please provide me with an emergency contact. This person would only be contacted in an emergency situation (medical or psychological) and by signing below you give permission for me to contact this person directly.

**Emergency Contact**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Full Name Relationship Phone Number(s)

**Agreement:**

By signing this document, you are indicating that you have read the contents, asked any questions you may have regarding the contents, and have received a copy for your own records (per your request).

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

Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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