Light The Way Christian Counseling Center
Consent for Treatment/Confidentiality of Child

I voluntarily consent to and authorize treatment for my child/dependent by Light The Way Christian Counseling Center's staff as defined in the treatment/service plan in which I am an active participant. I understand that my cooperation and active participation in my child's/dependent's treatment are necessary to achieve the goals and objectives of treatment. I understand that I may withdraw my consent at any time.

Confidentiality

You should be aware that, pursuant to HIPAA, your child's/dependent's therapist will keep Protected Health Information (PHI) about him/her in his/her record. The medical record includes information about the reason for seeking therapy, the diagnosis, goals that are set for treatment, therapy notes, and billing records etc. This information will be kept confidential as outlined in our Notice of Privacy Practices for Protected Health Information. If you would like a copy of this Notice, please discuss with your therapist.

Electronic Communication Consent

If you and the therapist choose to communicate by email, text message, or other electronic methods of communication, be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate, there is a reasonable chance that a third party may be able to intercept these messages. Some of the potential risks you might encounter include:

- People in your home or other environments who access your phone, computer, or other devices that you use might read your email or text messages
- Loss of cellular phone, computer, or other devices
- Email accounts can be hacked
- Text messages and emails are stored on servers
- Misdelivery of email to incorrectly typed address
- Third parties on the internet such as server administrators who monitor internet traffic might intercept your communication

Please limit the use of electronic communications to issues related to scheduling. If you choose to email or text please be aware the therapist's responses may be brief or they may call you to discuss the matter, responses may also be delayed until business hours.

I authorize communication by (Please check any that apply): ____ Phone ____ Mail ____ Text ____Email

Phone #:_____ Email Address:_____

(Turn Over)

Regarding Your Child/Dependent's Therapy

If married either you or your child's other parent may give consent. If you are separated, but not divorced, either parent may provide consent unless you present a court order to the contrary. In the case of divorce, we request that you provide a copy of the divorce decree stating who is responsible for health care decisions. In the case of guardianship, a signed power of attorney is requested from the guardian prior to treatment.

If you are separated or divorced, best practice dictates our office should provide notification to the other parent that the child is receiving services. Please provide the following information so a letter may be sent:

Parent's Name: _____ Phone: _____

Address:

_____

(Street) (City) (Zip)

If you choose to not have the parent notified, please initial the line below and provide reason for denial:

____ By initialing I am stating I do not have or refuse to give contact information for my child's other parent or a court order addressing parental rights, custody, etc.

Reason for Denial: _____

_____

Consent

I certify that I have read the above statements, that I understand it, and that any questions I have raised about it were answered to my satisfaction.

Print name of Client_____

Print name of Parent/Guardian_____

Signature of Authorization_____ Date: _____