Consent to the Treatment of a Minor Child

I, ____ _______________________ ,
(Name of Legal Guardian - Please Print) (Date of Birth)

confirm that I am the legal guardian of _______________________________________ _______________________,
(Name of Minor Child – Please Print) (Date of Birth)

by virtue of ❐ being his/her biological parent,
or ❐ having been granted Guardianship by Court Order (ref. Child, Youth, and Family Enhancement Act).

As the above-named child's legal guardian, I **affirm** my belief that the psychological counseling and/or psychological assessment services offered by Dr. Michelle L. Ranson, Registered Psychologist, are presently in my child's best interest. Accordingly, I ***consent*** to his/her treatment with Dr. Ranson, as my signature below validates.

In providing my consent for Dr. Ranson's treatment of my minor child, I **acknowledge** my understanding of the following:

- Because he/she is a minor, my child is not legally entitled to the content of his/her sessions being held in confidence by the psychologist. However, in order for treatment to be effective, a trusting relationship must exist between a client and his/her psychologist. Trust is best established when the child understands that he/she can be open and honest in disclosing his/her thoughts, feelings, and behaviours, without his/her privacy being compromised with disclosures to others. Accordingly, I understand that psychologist-patient confidentiality will be upheld in the treatment of my child, and I waive my right of access to the content of my child's sessions.

- I understand that I will be told immediately if my child discloses that s/he is involved in (a) any activity that puts him/her at serious risk of harming him/herself or another (e.g., suicidal behaviour, chronic drug/alcohol use), or (b) experimental activities that are not developmentally age appropriate (e.g., alcohol experimentation by a child in elementary school).

- I understand that I will be given regular updates on the progress of treatment, and that details will be provided as my child is comfortable and gives his/her assent for disclosure. I also understand that I will be informed immediately if my child does not attend a scheduled session.

- I understand that counselling has benefits and risks. I understand that one risk of child therapy involves disagreement among the child's parents and/or disagreement between the parent(s) and the psychologist regarding the best interests of the child. If such disagreements occur, I will calmly explain my perspective to my child's psychologist and expect that she will listen carefully in an effort to understand my position. I will also listen carefully to her position, understanding that she does have the best interests of my child in mind. We can resolve such disagreements, or we can agree to disagree, so long as my child appears to be making progress.

- I understand that I have complete control over the decision to support my child's treatment or to terminate his/her treatment at any time. In making this decision, I will consider my child's preferences, as well as the recommendations of the psychologist providing treatment; however, ultimately, I will act in what I believe to be my child's best interests. If I decide to end the treatment when my child prefers not to, I will allow one or two final sessions so that the treatment relationship can be brought to an appropriate, rather than abrupt, end.

My signature, below, indicates that I have read and understood the information in this document and agree to abide by its terms.

_______________________________________ _______________________________
(Parent or Guardian Signature) (Date)

_______________________________________ _______________________________
(Witness Signature) (Date)