Courtney Poignand, LMHC, CAGS, CHC, KYT

PARENTAL CONSENT

THANK YOU FOR TRUSTING ME TO ASSIST YOU WITH YOUR PERSONAL CONCERNS AND WELLBEING. PLEASE TAKE THE TIME TO READ, UNDERSTAND AND SIGN THIS DOCUMENT REGARDING YOUR CONSENT FOR ME TO WORK WITH YOUR CHILD. PLEASE ASK ME IF YOU HAVE ANY QUESTIONS.

Courtney Poignand, LMHC, CAGS, CHC, KYT will provide psychotherapy services to your child(ren)

_____

_____

The goal is to help your child(ren) be successful emotionally, socially and academically. Individual, couple and family counseling is available to enhance your child(ren)'s success. I am requesting your involvement, and need permission to see your child.

This consent is valid until termination of the therapeutic relationship. You have the right to revoke consent at any time. Verbal or written notification will be accepted.

I understand the information stated in this form and give consent for my child(ren)_____

_____

to receive therapeutic counseling with Courtney Poignand at 23 Brewster Cross Road, Orleans, MA 02653.

Date:_____ Relationship:_____

Parent's Signature: _____

Parent's Name: _____

Home Phone: _____ Cell: _____

OK to leave message? Yes No OK to leave message? Yes No

Home Address: _____

City, State, Zip_____

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PARENTAL CONSENT

Child(ren's) names_____

_____

If child's parents are legally separated or divorced, please complete the following regarding:
Legal Custody:

Mother_____% Father _____%

Physical Custody:

Mother_____% Father _____%*Please provide a copy of the custody agreement.

Confidentiality

For therapy to be effective, confidentiality must be honored. No information will be shared with a party outside of my office without your written consent. Additionally, information your child shares with me in his/her private sessions will be held confidential. However, the goals and progress of the counseling may be shared with you, any other legal custodial parent or guardian. By law, confidentiality must be breached if a therapist or therapist intern suspects that any minor is being or has been abused, if a person plans to physically harm another person, or if a person plans to harm him/herself. Additionally, breaching of confidentiality will occur if a therapist or therapist intern hears that an elder or dependent adult is being or has been abused.

Eligibility and Fees

My services are available to individuals, couples, groups, adolescents, children as well as families. I will collect copay at time of visit and bill your insurance company for each session. Please note that phone calls, emails and outside involvements that exceed 5 minutes will be charged at $1.75/minute. Please make checks payable to "Courtney Poignand".

Courtney Poignand, LMHC, CAGS, CHC, KYT

PARENTAL CONSENT

Child(ren's)
names_____

_____

Policies Regarding Appointments

Individual and couples therapy appointments are generally 50 minutes and typical child therapy appointment are 45 minutes. If you cannot make a scheduled appointment, it is your responsibility to call 774/722-5190 to cancel within 24 hours or you will be responsible for payment.

In an Emergency

In the rare event that you or your child need immediate help at a time when Courtney Poignand is not available or cannot return your call, please call 911 or go to the nearest Emergency Room and ask for the mental health professional on call.

NOTE

Please be mindful that email and texts are not secure forms of communication, so use discretion in what you write. You can reach me by text or email for general things but cancellations of appointment are required to be done by phone or a voice message.

Parent's Signature: _____

Parent's Name: _____

Counselor's Signature: _____