# Kristen Cheesman, MA, LMFT, CFI

## CONSENT TO TREATMENT OF MINOR CHILD

Name of Child:_____ Child DOB:_____

1. Consent to Evaluate/Treat: I voluntarily consent that my child will participate in a mental health evaluation and/or treatment with Kristen Cheesman, MA, LMFT, CFI. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning assessment results and treatment plan.

2. Benefits to Evaluation/Treatment: Evaluation and treatment may be administered via psychotherapy, art and play therapy, and other modalities that best fit the needs of my child. It may be beneficial to my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

3. Charges: Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

4. Confidentiality, Harm, and Inquiry: Information from my child's evaluation and/or treatment is contained in a confidential medical record, and I consent to disclosure for use by Kristen Cheesman, LMFT, CFI for the purpose of continuity of my child's care. Per Colorado mental health law, information provided will be kept confidential with the following exceptions:

    a. if my child is deemed to present a danger to himself/herself or others;
    b. if concerns about possible abuse or neglect arise; or
    c. if a court order is issued to obtain records.

5. Right to Withdraw Consent: I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.

6. Expiration of Consent: This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

_____ _____

Signature of legal guardian for minor under age 18 Date