Active **Enhancement,** LLC

Kenny Wolford, M.A., M.F.T.

Consent for Treatment & Release of Liability

To be completed by a parent/guardian. Please answer all applicable sections read the terms, sign and date on the final page and return to: Kenny Wolford, M.A., M.F.T. - PO Box 19572 - Portland, OR 97280 Questions Call: 503.752.8688

Child/Adolescent Information

Child's Name: _____ Today's date: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Birth Date: _____ Age: _____ Gender: _____

Current Grade: _____ School _____ Teacher _____

Parent/Guardian Information or Agency Information (if applicable)

Name(s): _____ Agency Name: _____

Spouse's Name (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone: _____

Please enter complete e-mail address:

_____

Is your email confidential? **Yes** **No** Voicemail Confidential? **Yes** **No**

Medical Information:

Is the child/adolescent on medication?: **Yes** **No**

Does the child/adolescent have any know medical or physical problems? **Yes** **No**

If Yes to either of two questions above, desribe diagnosis or condition:

Child/Adolescent's Physician:

Name: _____

Address: _____

Phone: _____

Child/Adolescent Health Insurance Coverage:

Provider: _____

Policy #: _____

Address: _____

Phone #: _____

Siblings of Child/Adolescent

Name	Age	Relation

Child/Adolescent's Living Situation:

Describe what brings you and your child to counseling/therapeutic mentoring at this time?

What do you hope to gain through counseling/mentoring?

What have you already done to deal with the difficulties?

Has your child had previous psychological counseling or psychiatric help?

What are your child's biggest strengths?

Confidentiality: I do not provide services to minors without the written permission of parent (s), court order or the legal guardian. Minors who are 14 or older can seek treatment without parental consent. It is my policy to work with children only when the parent(s)/guardian is involved. Minors under the age of 14 who are not emancipated (and their parents) should be aware that the law may allow parent(s)/guardians to examine the child/adolescent's treatment records. However, privacy in therapy/mentoring is crucial to progress (especially with teenagers) and therefore it is sometimes my policy to protect the confidentiality of the child/adolescent and request that parent(s)/guardian not request to view treatment records.General information will be provided verbally in these cases. If I feel that the child/adolescent is in danger or a danger to someone else, notification of my concern will be expressed in writing to the parent(s) or guardian.

Parent(s) or guardians should also be aware that psychotherapy and therapeutic mentoring often requires that information be shared among other professionals. In these cases, a signed release of information will be required specifically outlining the persons or agencies involved.

There are four major exceptions to confidentiality that Oregon law requires all mental health professionals to report to the proper authorities:

1. Incidences of child or elder abuse or neglect.
2. Intent to commit suicide.
3. Threats to do harm to yourself or another person.
4. Court order.

Release of Liability: As the Parent(s)/Guardian of _____ I hereby release Kenny Wolford, M.A., M.F.T./Active Enhancement, LLC from all liability resulting either directly or indirectly from psychotherapy/therapeutic mentoring. This includes any liability from accident while transporting the child/adolescent to and from therapeutic sessions. While all safety and security precautions are taken to insure the child/adolescent's well-being, there may be factors or the behavior of the child or adolescent that are out of my direct control. If a child/adolescent is putting either him/herself in danger or the therapist, the parent(s)/ guardian will be called immediately to come and pick up the child/adolescent. If the parent/ guardian is not available, the therapist will call 911 and request that the police department intervene.

By signing below, the parent(s)/guardian of _____ have read and understand all aspects of this form and agree to the terms and conditions of their child/adolescent receiving psychotherapy/therapeutic mentoring from Active Enhancement, LLC/Kenny Wolford, M.A., M.F.T. The signed agreement also certifies that payment will be made in full at the time of psychotherapy/therapeutic mentoring unless other arrangement have been made.

Printed Name (Legal Parent(s) or Guardian): _____ Date _____

_____ Date _____

Signature (Legal Parent(s) or Guardian): _____ Date _____

_____ Date _____