Tiffany Griffiths, Psy.D. & Associates, Inc.
Consent for Treatment of a Child

Name of child client (13 years of age or younger): _____

This is to certify that I give permission to Tiffany Griffiths, Psy.D. & Associates to conduct a diagnostic evaluation, to provide psychotherapy and, if elected, to prescribe medication for my child.. I understand that my case may be discussed at peer consultation meetings and as needed with other licensed colleagues for consultation purposes. In these cases, identifying information will not be used so as to protect my privacy. In addition, I understand that my case will be discussed between my intake evaluator, and, if applicable with my prescribing physician/nurse practitioner and/or clinician conducting psychological testing at Tiffany Griffiths, Psy.D. & Associates, Inc. in order to coordinate care. My child will be treated with respect and honesty throughout treatment. He/she is expected to benefit from treatment, but there are no guarantees. Maximum benefits will occur with regular attendance but I understand that I may see a temporary worsening of symptoms while my child is in treatment.

I am aware that requesting a forensic report or testimony as to any of the content of my child's treatment greatly jeopardizes the course of treatment as well as the therapeutic relationship. Therefore, I knowingly and freely waive my right to request the release of information (other than dates of sessions, length of sessions, attendance at sessions, and fee information) to my attorney or any other Officer of the Court. I understand that release of clinically significant information to any Officer of the Court shall be by Court Order, signed by a duly appointed Judge, only.

I understand the importance of confidentiality between my child and his/her therapist. I will respect the confidentiality of my child and I understand that his/her therapist will communicate with me when there are any treatment concerns and/or if my child is in danger. My child's diagnosis, course of treatment, treatment plan, and treatment prognosis will be communicated. I will notify my child's therapist of any changes in behaviors and/or symptoms while my child is in treatment.

Pennsylvania State Law mandates the reporting of actual or suspected child or elder abuse to the appropriate agency. It has also been upheld that if an individual intends to take harmful or dangerous action against another, it is the therapist's duty to warn the person or the family of the person who is likely to suffer the results of harmful behavior. Similar actions are taken with clients who may have had suicidal thoughts and desires.

I have had the chance to discuss all of these issues and have had my questions answered. Therefore, I agree to play an active role in this treatment as needed and I give permission to begin this treatment as shown by my signature below.

_____ ____/____/____
Signature of parent/guardian Date

*_____ ____/____/____
Signature of parent/guardian Date

*Please note that if the child's parents are separated or divorced we require the signature of both parents if there is joint legal custody.