DR. RICHARD FEDERICI, LLC

Dr. Richard Federici
Licensed Clinical Psychologist

ADOLESCENT CONSENT FORM
AND
PARENT AGREEMENT TO RESPECT PRIVACY

Patient Name: _____ Date of Birth: _____

Adolescent Patient:

Signing below indicates that you have reviewed Dr. Federici's *Confidentiality Policies* and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask Dr. Federici at any time.

Patient's Signature _____ Date_____

Parent/Guardian:

(Please initial af each line and sign below, indicating your agreement to respect your child's privacy)

___/____ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

___/___ I agree to allow my child to have a zone of privacy and I will respect the confidentiality of my child's/adolescent's treatment.

__/___ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to Dr. Federici's professional judgment.

By initialing above, I agree to abide the parameters stated to allow my child to have privacy in therapy. I also acknowledge that I do not have to be informed about my child's sexually transmitted diseases, terminated pregnancy, or substance abuse, nor will I attempt to obtain any information by any means, that may be legally available to me.

Parent's Signature _____ Date_____

Parent's Signature _____ Date_____