PARENT/GUARDIAN OF MINOR PATIENT

Name of Child _____ **Child's Date of Birth** _____

With Whom Does Child Live?_____

Please initial after 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 the Dr. Federici's professional judgment. _____ _____

_____	_____	_____
Signature of Parent or Guardian	**Print Name**	**Date**
_____	_____	_____
Signature of Parent or Guardian	**Print Name**	**Date**

If applicable, I also attest that I am the legal guardian and have the right to consent for the treatment of this minor

_____	_____	_____
Signature of Patient or Guardian	**Print Name**	**Date**

The undersigned agrees to be financially responsible for this account, and will pay promptly after each session.

_____	_____	_____
Signature of Patient or Guardian	**Print Name**	**Date**

_____	_____	_____
Relation	**A ddress**	**Phone**