Angie Simonton, LCSW
Individual & Family Clinical Social Worker
5001 Highway 190 E. Service Road
Suite D4-5 Covington, LA 70433

Informed Consent Form
For Treatment Of A Minor
For All Legal Guardians Under the Care of Angie

Please Print Minors Name:

_____

I am giving consent for the above minor to receive mental health treatment under the care of Angie Simonton, LCSW. I understand Ms. Simonton requires that this is completed and signed by hand by all guardians of a minor. The Louisiana Law and the Louisiana Board of Social Work Examiners state that the consent for treatment is required for a person under the age of 18 years old for outpatient mental health counseling. I understand that this is required even if there is a domicile parent, joint custody, and despite marital status.. There are few circumstances for which this form will not be required, and if this does not apply then I understand that I should use the "Sole Guardianship" form. I understand that if I seek mental health treatment without the consent of the other guardians approval, that it could be used against me in a court case (if one occurs). I understand that either legal guardian can terminate the counseling relationship at any point. And that Ms. Simonton is required to follow that.

I understand that Ms. Simonton has the ability to diagnose and treat mental health disorders in the DSM V. I understand that Ms. Simonton is a Clinical Social Worker and will be providing my child with outpatient counseling services. I understand that Ms. Simonton can not prescribe psychotropic medications, and will refer my child to a psychiatrist or medical prescribing psychologist if needed. If additional testing is required, Ms. Simonton will refer my child to an appropriate professional. I understand that the counseling relationship is very important and I will trust her judgment in the mental health treatment of my child. I do have the right to know what is occurring with my child in treatment, and Ms. Simonton will encourage this to occur in a family session. I also can request a session without my child present as apart of my child's treatment. I understand that Ms. Simonton does feel that parental involvement is imperative to the most effective outcome for a child, and thus I will remain involved as much as able. I understand that Ms. Simonton would like email updates at angie@angiesimontonlcsw.org for any issues during the week that I would like addressed in treatment with my child. I understand her email is HIPAA compliant but her cellphone number (text messages) are not. It is preferable that text messages be used only for scheduling purposes.

I understand the above information and give consent for my child to receive mental health treatment under the care of Angie Simonton, LCSW.

This form is to attempt to protect all parties involved in the event of a court case. As they are unfortunately very common in working with children. Thank you.

Printed Name of Parent/ Guardian (1)

_____

Signature

_____

Relationship to the minor

_____

Date

_____

Printed Name of Parent/ Guardian (2) Write N/A
If not applicable.

_____

Signature

_____

Relationship to the minor

_____

Date

_____

Angie Simonton, LCSW

_____

Date