



Consent For Treatment Of Minor(s)

I _____, the holder of privilege (parent, guardian, etc.) give my consent for Dr. Andreas DiMeo/Dr. Stephen Seetal to conduct psychotherapy with _____.

I have been informed of the limitations to confidentiality in the Office Policies form, which I have read and signed. I understand that special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept Dr. Andreas DiMeo/Dr. Stephen Seetal's judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the patient's wellbeing.

If you are under eighteen years of age, please be aware that the law may give your parents or guardians the right to obtain information about your treatment and/or examine your treatment records. Dr. Andreas DiMeo/Dr. Stephen Seetal will provide them only with general information subject to your approval, or, information that is important for them to know in order to make sure that you and people around you are safe. If appropriate, Dr. Andreas DiMeo/Dr. Stephen Seetal may involve your parents or guardians if there is a high risk that you will seriously harm yourself or another/others. Before giving them any verbal or written information, the matter will be discussed with you, if possible. Efforts will be made to resolve any differences that you and your psychologist may have about what to discuss with your parents or guardians.

Parent/Guardian (print) Relationship Signature Date

Minor (print) Signature Date