Valliere & Counseling Associates, Inc.
Forensic Treatment Services

Check appropriate program involvement:

☐ Valliere & Counseling Associates, Fogelsville, PA
☐ Forensic Treatment Services, Allentown, PA

PARENTAL CONSENT FOR TREATMENT OF A MINOR

I, _____, give my consent for my child to be involved in treatment. I understand that the treatment is voluntary and can be voluntarily terminated by my child, myself, or another guardian. I agree that I am able to expect ethical and competent treatment, but have not been promised a cure or definitive relief from my child's symptoms. I understand that therapy is a process and relies on cooperation, honesty, motivation, and willingness to follow therapeutic recommendations. Success is in no way guaranteed.

I understand that treatment may be terminated involuntarily for failure to show for 2 or more appointments or no contact within 21 days. I may also be discharged if my counselor determines there is a lack of treatment amenability or a lack of cooperation with treatment. I will be notified of termination from treatment. I can expect a referral is Valliere & Counseling Associates cannot adequately meet treatment needs. I understand the limits to confidentiality and that access to records can be dictated by law and/or discretion of the treatment professionals.

_____ _____
Signature of Parent Date

I REFUSE to allow Valliere & Counseling Associates to treat my child. I am unwilling to participate in my child's counseling and wish Valliere & Counseling Associates to cease treatment upon receipt of this form.

_____ _____
Signature of Parent Date

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