Madison Youth & Family Services
SUPPORT • COMMUNITY • EMPOWERMENT

Outpatient Clinical Services
Agreement to participate in treatment

I (Parent/Guardian)_____, consent for clinical services to be provided for (Child/Youth) _____, DOB_____, at Madison Youth and Family Services. All clinical services include an initial assessment and ongoing treatment as mutually agreed upon. The following Service(s) will be provided with my informed consent:

(*check and initial)*
☐ Individual Therapy
☐ Family Therapy
☐ Parent Support Counseling

I consent for the above services and I am aware that my consent will expire when the service is terminated. A client involved in clinical services at Madison Youth and Family Services can expect that all information shared will be kept confidential per ethical/legal standards and not be shared with outside agencies without a signed Authorization to Release/Obtain protected health information. Information between Madison Youth and Family Services clinical programs will be shared as clinically necessary for the purposes of clinical supervision, case coordination and to ensure optimal therapeutic benefit.

Madison Youth Services protects the rights of its clients to confidentiality by following procedures and polices, which are in compliance federal and state laws that are explained in the Notice of Privacy Practices as well as the HIPAA Authorization. I also understand that Madison Youth Services values a child's willingness to engage therapeutically with his/her counselor, and therefore will allow information at the counselor's discretion and/or child's request to be held in confidence between them, so long as there is no concerns for the child's immediate physical safety or the safety of others.

Child/Youth _____ Date _____

Parent/Guardian _____ Date _____

Parent/Guardian _____ Date _____

Witness_____ Date _____