

My Whole health Life, LLC

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**Child and Adolescent Informed Consent Form**

The purpose of this form is to share some important principles, which guide my counseling process so that your decision to place your child or adolescent into counseling with me can be based on accurate, informed expectations. Please read this carefully and feel free to ask any questions about what you have read or to have further clarification. Informed consent is the parent’s and/or the child or adolescent’s full and active participation in decisions that affect them, and freedom of choice based on the information shared. It is a continuous process throughout the counselling relationship.

The parent and/or child or adolescent have the right to refuse and/or withdraw from treatment at any time.

PROFESSIONAL DISCLOSURE STATEMENT

Qualifications:

Dr. Cleyde Crofoot, graduated from the Florida Christian University in 2002 with a Master of Degree in Christian Clinical Psychology, and in 2004 with a PhD in Christian Clinical Psychology/Counselor. I hold a License in Christian Clinical Counselor # LCCC 052784 from US Agency for Christian Counseling Credential and Accreditation, in accordance with ACCCA – Rule 300, and the FS 491.014 (3). I obtained a BA of Ministry in Christian Psychology from the Florida Christian University. I am Yoga Therapy Instructor, and I am Certified in Anger Management, Grief and Certified from National Center for Creative Aging. Ongoing professional development includes workshops on Anger Management Children and Adolescents, Parenting, Addiction to Healing, and Depression.

Experience:

For the past 20 years I have worked with individuals of all ages from children to adults. My work has also included couples and families. I have helped individuals work through issues such as depression, addictions, angry issues, panic and anxiety, grief and loss, self-esteem, trauma, and abuse. My education also included four years of internship training at Salvation Army ARC. The training connected me with clients of diverse backgrounds, cultures, and experiences. I have worked in community agencies providing therapy to individuals dealing with issues such as, substance abuse and general personal and relationship concerns. I have also worked as a counsellor in a private Company for addictions and behavioral issues.

Nature of Counselling:

Our sessions offer a safe place to explore any issues that you might be experiencing. My own journey to wholeness reflects my personal faith in Christ. I do not presume that all clients want or will be receptive to a Christian perspective in counseling. As the client, should you wish to explore issues of faith in our counseling sessions, I welcome that conversation. It is not assumed that faith will be a part of the counseling therapy, however you could bring any and all faiths into the counseling session should you so desire.

I approach counseling from a Holistic Integrative perspective using modalities such as Cognitive Behavioral, Mindfulness, Art Therapy. Techniques can include active listening, homework, psych educational discussions, relaxation technique, role-playing, empty chair, and play therapy. I also use EMDR and EFT in addictions and trauma.

I believe that clients have the capacity and resilience to resolve their own problems and make their own decisions. However, from time to time all of us need assistance, support and direction and I will work with you to establish goals for your therapy.

INFORMED CONSENT FOR CHILDREN AND ADOLESCENTS

Counseling can have benefits and risks. Since therapy often involves discussing unpleasant aspects of one’s life, your child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has been shown to have benefits for individuals who go through it. Therapy can lead to better relationships, solutions to specific problems, significant reductions in feelings of distress and improved self-esteem. But there are no guarantees of what they will experience. Counseling is a personal exploration and may lead to major changes in their life perspectives and decisions. Together you, your child and I will work to achieve the best possible results for him/her.

Confidentiality:

In general, one of the most important rights the person seeking counselling has involves confidentiality. Information revealed by a client during the counseling will be kept strictly confidential and will not be revealed to any other person or agency without written permission, with the following exceptions:

• Counselors need to consult with other colleagues from time to time to gain assistance and insight in providing quality and helpful service. To maintain professionalism counselors may also be supervised by other counselors. Regardless of the situation, every effort will be made to retain as much confidentiality of the client as possible.

• According to provincial law, confidentiality has some legal limits as well. There are situations where a counselor can be required to reveal information obtained during therapy to another person or agency without the parent or child’s permission. These situations involve danger to self, danger to others, and child abuse. In addition, counselor notes on sessions can be subpoenaed in a court of law.

• If I’m authorized or directed in writing to release information.

• In the event of a medical, psychiatric, or psychological emergency (suicidality, I ask that I be allowed to contact a family member or other person in order to offer a more thorough support).

Children, Adolescents and Confidentiality Counsellors who work with children and adolescents have the difficult task of protecting the minor's right to privacy while at the same time respecting the parent's or guardian's right to information.

Therapy is most effective when a trusting relationship exists between the counselor and the child/adolescent. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a “zone of privacy” whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child’s consent. At the end of your child’s treatment, we will review the sessions in general including what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

Obtaining Parental Consent

(Please check one)

( ) Parent has sole custody and sole guardianship and can only give consent.

( ) One parent has sole custody who can give consent and the other parent has sole guardianship.

( ) Parents share joint custody and one parent has sole guardianship. Either can give consent, however consent from both parents is preferred.

( ) One parent has sole custody but both parents share joint guardianship. Custodial parent has final consent.

( ) Parents share joint custody and joint guardianship. Either custodial parent can give consent, however consent from both parents is preferred.

Parent contact information:

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Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

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Telephone/Cell

**Clients Rights**

Fees and Appointments:

The standard individual counselling fee is $80.00 plus for a 50-minute session payable at the end of each session. Cash, Debit, Check, Visa, MasterCard, American Express or check made payable to “My Whole Health Life.” Returned checks will be charged a $25 service fee. Should you be unable to pay for all or part of a session, please speak with your counselor. The fee for family counselling is $120.00.

Counselling Relationship:

It is helpful to remember that our relationship is professional and not social. Our professional relationship is of utmost importance as we work together towards achieving your goals and bringing resolution and healing to your life.

OFFICE HOURS

My Whole Health Life Clinic’s office hours are by appointment. Should you need to contact your therapist outside of your regularly scheduled appointment time, please call (407) 203-5090.

RESCHEDULING APPOINTMENTS

It is our policy to schedule you for a “standing appointment.” If you occasionally need to come at a different time, ask your counselor, who will see if an alternative appointment time is available. Please be aware that repeated cancellations or “no-shows” will result in the loss of your standing appointment.

CANCELLATIONS

If you must cancel your appointment, please contact your counselor at least 24 hours in advance of your scheduled time. You may call any time of day or night and leave a confidential voice mail message. Failure to do so will result in you being charged the full professional service fee, payable on your next visit. Your counselor has reserved a room for your session and has made herself available for you at this time. Advance cancellations allow us to make the most efficient use of counselor time and office space.

NO SHOWS

If you fail to show up for an appointment and have not notified your counselor at least 24 hours in advance, you will be considered to have been a “no-show.” It is your responsibility to contact your counselor before your next session to confirm your next appointment by leaving a message on her voice mail. After hearing from you, your counselor will then confirm your next appointment.

Both you and your child are in complete control and may end the counselling relationship at any time, though I do ask that you both participate in a termination session. You both also have the right to refuse or discuss modifications of any of my counseling techniques or suggestions that you believe might be harmful.

If you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may contact the US Agency for Christian Counseling Credentials & Accreditation to file a complaint.

Late arrivals:

As the parent you understand that if you and your child are late arriving at the counselor’s office and therefore attend only a part of a scheduled appointment that you are nonetheless responsible to pay the counselor the full fee that would be charged for the total time of that appointment.

Cancellation:

Please contact the office if you discover that your child will not be able to keep an appointment. I require 24 hour’s notice of cancellation. Unless the missed appointment is due to illness or an emergency, you will be charged a $75.00 plus for the missed appointment without advanced notice.

**Emergency:**

**If there is an emergency between sessions, please contact your family physician, the local hospital emergency room, 911 or the Crisis line at Hotline: 800-500-1119  
Phone: 850-425-2749.**

CONTACTING YOUR COUNSELOR

You may leave a confidential voice mail message for your counselor by calling (407) 203-5090.

Licensed Christian Clinical Counselor, # LCCC 052784

Dr. Cleyde Crofoot, PhD. LCCC.

knowledgment and Consent:

By your signature below, you are indicating that you read and understood this consent form or that any questions you had about this consent form were answered to your satisfaction, and that you were furnished a copy of this document.

Consent for Treatment of Minors:

I / we consent that my son/daughter/child under the age of 19,

(\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) may be treated as a client by Dr. Cleyde Crofoot.

Parents:

**Do not leave the office while your minor child is with his/her therapist. Your presence is necessary during your child's visit. In addition, it may be necessary for me to speak with you at some point during your child's session.**

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent or Guardian’s name (please print) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cleyde Crofoot PhD, LCCC |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent or Guardian’s Signature | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |