

## **Agreement for Individual Counseling with Legal Minor**

I, the client, agree to take part in individual counseling with the counselor named below.

I authorize this counselor to disclose to all my parents/guardians, in general terms only, how my counseling is going and my attendance at my appointments. I understand that my counselor may be required by law to disclose additional information, but that he will limit such information to the minimum required. I understand that this counselor may notify my parents/guardians or the appropriate governmental authorities if he believes that I am in immediate danger for any reason. I authorize this counselor to continue these limited disclosures to my parents/guardians after my 18th birthday, as long as they continue to be responsible for payment for my counseling with this counselor.

I understand that my parents/guardians will be charged for all of my appointments, even those I do not attend or which are canceled with less than 24-hours advance notice. The only exceptions are unforeseen or unavoidable situations arising suddenly, which will be determined by this counselor on a case-by-case basis.

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name: \_\_\_\_\_

I, the counselor, have met with this client for a suitable period of time, and have informed him or her of the issues and points raised in this agreement and the policies and practices of my counseling practice. I agree to enter into counseling with the client.

\_\_\_\_\_  
Tom McCabe, MA, LPC

\_\_\_\_\_  
Date

*This is a strictly confidential client health record. Redislosure or transfer is expressly prohibited by law.*