Hoffmann ψ Burchett Psychological Services, LLC
205 N. Williamsburg Drive, Suite F, Bloomington, IL 61704

Consent to Child Therapy Agreement

*I understand that if I decide to terminate treatment, my child's psychologist has the option of having a closing session with my child to properly end the treatment relationship.

*I am waiving my right to access to my child's treatment records.

*The psychologist will inform me if my child does not attend the treatment sessions.

*If necessary to protect the life of my child or another person, my child's psychologist has the option of disclosing information to me without my child's consent.

*I agree that the psychologist's role is limited to providing treatment and that I will not involve her in any legal dispute, especially a dispute concerning visitation, custody or custody arrangements.

*I agree to instruct my attorneys not to subpoena my child's psychologist or to refer in any court filing to what she has said.

*If there is a court appointed evaluator, and if appropriate releases are signed and a court order is provided, my child's psychologist will provide general information about my child which will not include recommendations concerning visitation, custody or custody arrangements (i.e., allocation of parenting time).

*If, for any reason, my child's psychologist is required to appear as a witness, the party responsible for her participation agrees to reimburse her at the rate of $360 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

______________________________ ______________
Parent/Guardian Signature Date

______________________________ ______________
Parent/Guardian Signature Date