Angie Simonton, LCSW
Individual & Family Clinical Social Worker
5001 Highway 190 E. Service Road
Suite D4-5 Covington, LA 70433

Informed Consent Form
For Treatment Of A Minor
For All Legal Guardians Under the Care of Angie Simonton, LCSW

I, _____
(Print Name Of Adult), am the legal guardian of _____
(Print Name of Minor receiving treatment). I am giving consent for this minor to receive mental health treatment under the care of Angie Simonton, LCSW. I understand Ms. Simonton requires that this is completed and signed by hand by all legal guardians of a minor. I understand that it is the Louisiana Law that Ms. Simonton require consent of treatment by all legal guardians of minors, which is the purpose of this form. I understand that Ms. Simonton requires this form to be completed whether my child's parents are together or not. I understand that this is required even if there is a domicile parent. There are few circumstances for which this form will not be required, and if this does not apply then I understand that I should use the "Sole Guardianship" form. I understand that if I seek mental health treatment without the consent of the other legal guardians approval, that it could be used against me in a court case. I understand that if I give false information to Ms. Simonton, that she will not support me in such a case and that this will be documentation.
I understand that Ms. Simonton has the ability to diagnose and treat mental health disorders in the DSM V. I understand that Ms. Simonton is a Clinical Social Worker and will be providing my child with outpatient counseling services. I understand that Ms. Simonton can not prescribe psychotropic medications, and will refer my child to a psychiatrist or medical prescribing psychologist if needed. If additional testing is required, Ms. Simonton will refer my child to an appropriate professional. I understand that the counseling relationship is very important and I will trust her judgment in the mental health treatment of my child. I do have the right to know what is occurring with my child in treatment, and Ms. Simonton will encourage this to occur in a family session. I also can request a session without my child present as apart of my child's treatment. I understand that Ms. Simonton does feel that parental involvement is imperative to the most effective outcome for a child, and thus I will remain involved as much as able. I understand that Ms. Simonton would like email updates at angie@angiesimontonlcsw.org for any issues during the week that I would like addressed in treatment with my child. I understand her email is HIPAA compliant but her cellphone number (text messages) are not. It is preferable that text messages be used only for scheduling purposes.
I understand the above information and give consent for my child to receive mental health treatment under the care of Angie Simonton, LCSW.

_____
Printed Name

_____

Signature

_____

Date

_____

Angie Simonton, LCSW

_____

Date