Scope of Practice & Informed Consent

I am informed and understand that Amistad addresses mental health issues and related symptoms. In this role, Amistad therapists will operate within their scope of practice and provide clinical outpatient psychotherapy services. These services are intended to address my child's treatment and clinical needs and are not intended to serve in any other manner including those described below. As a part of treatment, recommendations regarding family system issues and/or other psychosocial matters which are impacting my child may occur. I understand that consideration of these recommendations will be a vital part of the therapy process. Failure to consider clinical recommendations and implement therapeutic changes may create substantial obstacles to my child's treatment and limit my child's ability to benefit from the outpatient psychotherapy services being provided.

I understand services provided by Amistad **do not** include placement or custody recommendations or decisions — Initials _______

I understand services provided by Amistad **do not** include conducting a home study — Initials _______

I understand services provided by Amistad **do not** include attachment studies — Initials _______

I understand services provided by Amistad **do not** include making recommendations regarding whether or not a parent is a fit, competent, or capable parent — Initials _______

I understand services provided by Amistad **are not** forensic in nature and **do not** include determining if something has or has not happened to my child — Initials _______

I understand that in order to protect the sanctity and confidentiality of my child's treatment, Amistad **will not** be called upon to testify in court — Initials _______

I understand that in order to protect the sanctity and confidentiality of my child's treatment, my child's mental health records (i.e. psychotherapy notes) will be kept confidential from me — Initials _______

I am the identified client and I understand that in order to protect the sanctity and confidentiality of my treatment, Amistad will not be called upon to testify in court or provide documentation for court purposes. — Initials _______

I understand that Amistad believes it is rarely in the best interest of the client for their therapist to testify in court regarding treatment. However, occasionally testifying on behalf of the client is unavoidable or even beneficial. If the respective therapist is called upon for such, then monetary charges will be incurred to the client's account. A fee schedule is available upon request. — Initials _______

With my signature below and in accordance with my initials above, I am giving informed consent in regard to the psychotherapy services provided to my minor child or myself. I have had an opportunity to ask questions regarding Amistad's scope of practice and to address any concerns.

_______________________________ _______________
Client's Name Date of Birth

_______________________________ _______________ _______________________________
Client/Parent/Guardian Signature Date Clinician Signature

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