

**Pam Dyson, MA, LPC**  
15332 Manchester Rd., Suite 209  
Ellisville, MO 63011  
314-681-8272  
636-230-8600(fax)



## **Informed Consent for Assessment and Treatment**

Thank you for choosing me as your child's counselor. I realize that starting counseling is a major decision and you may have many questions. The information herein is in addition to the information contained in the Notice of Privacy Practices. I am legally and ethically responsible to provide you with informed consent. If you have other questions or concerns, please ask, and I will try my best to give you all the information you need.

### **My Qualifications and Credentials:**

I have an MA in Professional Counseling from Lindenwood University and I am a Licensed Professional Counselor (LPC) and a Nationally Certified Counselor (NCC). I am a member of the Association for Play Therapy (APT) and the Missouri Association for Play Therapy (MAPT).

### **Services:**

Prior to beginning treatment, it is important for you to understand my approach to child therapy. I offer counseling for children ages 3-12 in both individual and family sessions using play therapy. Play is the language of children and play therapy is a treatment approach that encourages children to play out their fears, worries, and conflicts. It is my policy to provide you with general information about treatment status. I will also meet with you on a regular basis to consult about changes as well as to find out how your child is managing both at home and at school. If I feel it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. Ultimately, you have the right to terminate treatment at any time. I will honor that decision; however, I ask that you allow me the option of having a closing session with your child to appropriately end the therapeutic relationship.

### **Goals:**

Goals for therapy may be specific (change in behavior, improved relations with friends or family), or more general (less anxiety, better self-esteem). The length of therapy depends on the complexity and severity of problems. I encourage parent participation in all phases of child treatment. As the parent, it is important for you to support your child's work with me, making sure that appointments are kept and offering encouragement as needed.

### **Benefits and Risks of Therapy:**

Therapy can be beneficial to your child in a variety of ways. Your child will receive emotional support, will learn to understand feelings and problems, and will be encouraged to try out new solutions to old problems. While therapy may provide significant benefits, it may also pose risks. Occasionally, a disagreement among parents and/or a disagreement between parents and therapist regarding the best interests of the child may occur. We can usually resolve such disagreements or agree to disagree, so long as this enables your child's therapeutic process. Therapy may also elicit uncomfortable thoughts, feelings or memories.

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**Confidentiality:**

Therapy is most effective when a trusting relationship exists between the counselor and the client. Privacy is important in securing and maintaining that trust. Specific details of the information children share with me in sessions is not shared with parents (unless the child gives me his/her consent) so as to encourage children to be honest and forthcoming and to maintain an emotionally safe environment for them. As part of the therapeutic process I encourage children to share information with their parents. However, there are specific exceptions to this confidentiality which include the following:

- When there is risk of imminent danger to your child or another person, I am required to take necessary steps to prevent such danger.
- When there is suspicion that your child is being sexually or physically abused or is at risk of abuse, I am mandated to take steps to protect your child, and to inform the proper authorities.
- When a valid court order is issued for health records, I am bound by law to comply with such requests.

It is my policy not to testify in custody battles. I do not allow treatment records to be read or reviewed by any person other than myself.

**Consent for Treatment of Minors**

I/We have read and understand the above.

I/We agree not to subpoena or ask for copies of my child's records, or testimony/evaluations from Pam Dyson, MA, LPC.

I/We consent that \_\_\_\_\_ may participate in the assessment and treatment offered by Pam Dyson, MA, LPC.

\_\_\_\_\_  
Signature of Parent or Legal Guardian of Minor Child      Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Legal Guardian of Minor Child      Date \_\_\_\_\_