CONSENT FOR TREATMENT OF MINOR

I, ___________________________________, give my consent that Christine A.

Volker, Ph.D., may conduct psychotherapy with

____________________________________, (DOB ___________________).

I have been notified and understand that all material discussed during the psychotherapy sessions is confidential and can be released only with my permission. I have also been informed of the limitations to the confidentiality in the Office Policies form that I have read and signed. These limitations include reasonable suspicion of child or elder abuse or neglect, when the client presents a danger to himself/herself or others, is gravely disabled, or as a gravely disabled minor, pursuant to legal proceedings and when you have given permission to me to release information and signed a release of information form.

Privacy and trust are key components of the therapeutic relationship. Special sensitivity may be required in releasing information that the minor discloses in session about certain topics such as drugs and sex. I expect that Dr. Volker will maintain my minor's privacy and I will accept Dr. Volker's judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the patient's well being.

____ , ________________

Signature of client Date

Christine A. Volker, Ph.D.
Licensed Clinical Psychologist
Psy 18161
1899 E. Roseville Pkwy, Suite 140
Roseville, CA 95661
(916) 8112-3004
DrV@christinevolker.com