Agreement for Meetings with Dr. Knight

I, _____, agree to meet with David Knight, Ph.D., _____ time(s) per week starting on _____. Our meetings will last about 50 minutes. When we meet, we may talk, draw pictures, play games, or do other things to help this therapist get to know me better and understand my problems, strengths, and goals.

I understand that my parent (or parents) or my guardian has a right to know about how I am doing in therapy. I agree that Dr. Knight may talk with my parent/guardian to discuss how I am doing. They may also talk about concerns and worries they may have about me. Or they may talk about things Dr. Knight and I decide my parent/guardian needs to know about. Sometimes Dr. Knight may meet with my parent/guardian without me. At other times we may all meet together.

The things I talk about in my meetings with Dr. Knight are private. I understand he will not tell others about the *specific* things I tell him. He will not repeat these things to my parent/guardian, my teachers, the police, probation officers, or agency employees. But there are two exceptions. First, because of the law, Dr. Knight *will* tell others what I have said if I talk about seriously hurting myself or someone else. He will have to tell someone who can help protect me or the person I have talked about hurting. Second, if I am being seriously hurt by anyone, Dr. Knight has to tell someone for my protection.

I understand that sometimes I may not feel good about some things we may talk about in our meetings. I may feel uncomfortable talking to Dr. Knight because I don't yet know him very well. I may feel embarrassed talking about myself. Some of the things we talk about may make me feel angry or sad. Sometimes coming to meetings may interfere with doing other things I enjoy more. But I also understand that coming to therapy should help me feel better in the long run. I may find that I will trust this therapist and can talk about things that I can't talk to anyone else about. I may learn some new, important, and helpful things about myself and others. I may learn some new and better ways of handling my feelings or problems. I may feel less worried or afraid and come to feel better about myself.

Any time I have questions or am worried about the things that are happening in therapy, I know I can ask Dr. Knight. He will try to explain things to me in ways that I can understand. I also know that if my parent/guardian has any questions, he will try to answer them.

I understand that my parent/guardian can stop my coming to therapy if he or she thinks that is best. If I decide therapy is not helping me and I want to stop, Dr. Knight will discuss my feelings with me and with my parent/guardian. I understand that the final decision about stopping is up to my parent/guardian.

Our signatures below mean that we have read this agreement, or have had it read to us, and agree to act according to it.

_____ _____
Signature of child Date

_____ _____
Signature of parent/guardian Date

I, the therapist, have discussed the issues above with the minor client and his or her parent/guardian. My observations of their behavior and responses give me no reason, in my professional judgment, to believe that these persons are not fully competent to give informed and willing consent.

_____ _____
Signature of therapist Date

___ Copy accepted by client and parent/guardian ___ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.