STEARNS MUSIC THERAPY, LLC
315 W. Dodds St. * Bloomington, IN 47403 * (812) 320-2679

Parent Communication Agreement

It is important to establish an understanding regarding communication between therapist, parents of a minor child receiving therapy treatment, and the minor child receiving therapy treatment. The law provides parents of minor children the right to review treatment records. However, therapy is often more effective with confidentiality between therapist and client, so it is my policy to request an agreement from parents that they limit access to the child's records. Therefore:

Communicating with Parents/Legal Guardians

Except for situations in which I believe you may cause serious harm to yourself or another person, or in which I am otherwise legally required to disclose information, I will not tell your parents or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of – or would be upset by – but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel you are in such danger, I will communicate this information to your parent or guardian.

Adolescent Music Therapy client:
Signing below indicates that you have reviewed the policy described above and understand the limits of confidentiality. If you have any questions as we progress with music therapy, you can your music therapist at any time.

Minor's Signature: _____ Date: _____

Parent/Legal Guardian:
Check boxes and sign below indicating your agreement to respect your adolescent's privacy:

[ ] I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

[ ] Although I know I have a legal right to request written records/session notes since my child is a minor, I agree not to request these records in order to respect the confidentiality of my adolescent's treatment.

[ ] I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Parent Name: _____ Signature: _____ Date: _____

Parent Name: _____ Signature: _____ Date: _____

Therapist Signature: _____ Date: _____