Cornerstone Christian Counseling

www.afsnm.com ♥ (575) 222-4588 phone ♥(575) 222-4590 fax

Scope of Practice & Informed Consent

I am informed and understand that Cornerstone addresses mental health issues and related symptoms. In this role, Cornerstone 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 Cornerstone **do not** include placement or custody recommendations or decisions. Initials _____

I understand services provided by Cornerstone **do not** include conducting a home study. Initials _____

I understand services provided by Cornerstone **do not** include attachment studies Initials _____

I understand services provided by Cornerstone **do not** include making recommendations regarding whether or not a parent is a fit, competent, or capable parent. Initials _____

I understand services provided by Cornerstone **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, Cornerstone **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 _____

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. I have had an opportunity to ask questions regarding Cornerstone's scope of practice and to address any concerns.

_____ _____

Minor Child's Name Date of Birth

_____ _____

Parent/Guardian Signature Date

_____ _____

Therapist Signature Date