



## Parent Consent for School Counseling

(students age 12 and under)

Dr. Cristina Davis, Psy.D., MA, LMHCA, (Lic.# MC61254589) has been hired as an independent contractor to support students on an as-needed basis for Seattle Christian students in grades K-12 and is prepared to support students on a wide variety of topics. She will be on campus Mondays and Thursdays from 10:30am to 2:30pm each week. For students age 12 and under, **parent consent will be needed prior to a student's first session.** If you would like your student to receive counseling services, please read and initial the statements below, and provide your student's information. Times will be coordinated on-site once consent has been received. We look forward to partnering with families and providing this service for students at SCS!

**Training and Degrees:** I received a Psy.D. and M.A. in Counseling Psychology from Northwest University. I did my clinical training at Monroe Correctional Complex, Western State Hospital, and Nebraska Mental Health Centers. I practice under the title of a Washington State Licensed Mental Health Counselor Associate (MC61254589.) I am supervised by Michelle Van Aken, LMHC, (LH00007429).

**Counseling Orientation:** My approach and conceptualization depends on each client's unique circumstances and needs. I have experience utilizing CBT, DBT, Skills System, Motivational Interviewing, Family Systems, mindfulness-based and behavioral interventions.

**Seattle Christian Schools** is paying for an independent contract counselor to provide therapeutic services to students, on-site at Seattle Christian Schools. If you understand and consent, initial here: \_\_\_\_.

**Therapeutic services** provided at Seattle Christian Schools as well as referrals made will be determined based on the need of the student and at the discretion of the independent contract counselor. If you understand and consent, initial here: \_\_\_\_.

**Seattle Christian Schools** will be paying for therapeutic services. However, for students 13 years of age or older, the content discussed in-session will not be disclosed to anyone without the consent of the student, excluding limits of confidentiality. If you understand and consent, initial here: \_\_\_\_.

**Important Disclosure:** Dr. Davis and Seattle Christian School have taken steps to preserve discretion. However, peers, teachers, or whoever else may be on campus potentially may observe when you meet with Dr. Davis, entering or exiting the location where you will meet with Dr. Davis, etc. If you understand and consent to the potential privacy risk, initial here: \_\_\_\_.

**Unprofessional Conduct:** If you suspect that my conduct has been unprofessional in any way or wish to inquire if there may be any formal complaints, please contact the Department of Health at the following address and phone number:

*Department of Health Counselor Programs, PO Box 47869, Olympia, WA 98504-7869 (360) 664-9098*

(over)

**Contacting Me by Phone:** You may leave me a voice message at (253) 670-2702. I check this message periodically and will typically return your call within 24 hours. Please limit your phone conversation needs to appointment scheduling and emergencies. In addition, I am in private practice and practice at the following locations: 33710 9<sup>th</sup> Ave. S, Suite 15, Federal Way, WA. 98003; and 24909 104<sup>th</sup> Ave. SE, Suite 101-A, Kent, WA. 98030.

**VERIFICATION OF MEDICAL CONSENT:** I, the undersigned, hereby agree and consent to the plan of care proposed to me by the Covered Entity. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse medical care. I will ask for any information I want to have about my medical care and will make my wishes known to the Covered Entity and/or its staff. The Covered Entity (Families First Mental Health Services, PLLC.), shall not be liable for the acts or omissions of others. If you understand and consent, please initial here: \_\_\_\_\_.

Yes, I give consent for \_\_\_\_\_ to meet with Dr. Davis for counseling services.

Student's name: \_\_\_\_\_

Parent/guardian name: \_\_\_\_\_

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Potential counseling topics: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_