

 **SOUTHWEST FAMILY**  
GUIDANCE CENTER & INSTITUTE

**Request For Services By A Child 14 Years Of Age Or Older**

**This form is to be used only when a child 14 years of age or older is requesting services on his/her own behalf.**

I, \_\_\_\_\_, certify that I am 14 years of age or older and am requesting mental health services for myself from Southwest Family Guidance Center & Institute (SWFGC). By signing below, I acknowledge that SWFGC has advised me of the desirability of involving my parent/guardian/family in my treatment. **I have decided that (please initial one option below):**

- \_\_\_\_\_ I would like to involve my parent/guardian/family in my treatment, if possible.
- \_\_\_\_\_ I would like my parent/guardian to be advised that I am receiving services from SWFGC, but
- \_\_\_\_\_ I do not want my parent/guardian to be involved in those services.
- \_\_\_\_\_ I do not want my parent/guardian to be advised that I am receiving services from SWFGC.
- \_\_\_\_\_ I understand that I always have the option to involve my parent/guardian/family in services.

Regardless of the option I select above, I understand that no one (including my parent/guardian) will receive information about my treatment without my express consent **except** to report suspected abuse or neglect, in cases of imminent threat of suicide, homicide, harm to myself, or harm to others, or as otherwise provided by law.

In the case of a medical emergency, suspected abuse or neglect, or an imminent threat of suicide, homicide, harm to myself, or harm to others, I agree that SWFGC may contact the following (must be a person 18 or over):

Name: \_\_\_\_\_  
Relationship to Client: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Alternate Phone Number: \_\_\_\_\_

\_\_\_\_\_  
Client's Printed Name

\_\_\_\_\_  
Client's Date of Birth

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist's Printed Name (With Credentials)

\_\_\_\_\_  
Date