### CONSENT TO TREATMENT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and bring any questions you have to our next meeting. If you decide to begin treatment with me, I will ask you to sign this document, which will represent an agreement between us.

# PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular issues you hope to address. There are many different methods I may use to deal with those issues. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, it may be beneficial to work on things we talk about during our sessions at home.

**RISKS AND BENEFITS**

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of one’s life, you or your child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and reductions in feelings of distress. But, there are no guarantees as to what your child may experience.

## MINORS

Parent Authorization for Minor’s Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from your child’s other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child’s treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child’s therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with Me

In the course of my treatment of your child, I may meet with parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child – not the parents/guardians nor any siblings or other family members of the child.

If I meet with you or other family members in the course of your child’s treatment, I will make notes of that meeting in your child’s treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child’s treatment record.

## CONFIDENTIALITY

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child’s permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

* Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
* Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm [and the police].
* Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
* Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am required by law to report the alleged abuse to the appropriate state child-protective agency.
* If there is a breach or refusal to pay your balance, the necessary information can be given to a collection agency or to a small claims court.
* I am ordered by a court to disclose information.

Disclosure of Minor’s Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a “zone of privacy” where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child’s treatment, but NOT to share specific information your child has disclosed to me without your child’s agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child’s risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

***Example***: If your child tells me that he/she has tried alcohol at a few parties, I would keep this information confidential. If you child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.

***Example***: If your child tells me that he/she is having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of “hypothetical situations,” such as: “If a child told you that he or she were doing \_\_\_\_\_\_\_\_, would you tell the parents?”

Even when we have agreed to keep your child’s treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child’s life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child’s problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor’s Treatment Records to Parents

The laws and standards of my profession require that I keep treatment records. Although the laws of California may give parents the right to see any written records I keep about your child’s treatment, by signing this agreement, you are agreeing that your child or teen should have a “zone of privacy” in their meetings with me, and you agree not to request access to your child’s written treatment records.

Parent/Guardian Agreement Not to Use Minor’s Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child’s parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent’s custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $300 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

As part of my practice, I participate in consultation with other mental health professionals. During consultation, identifying information is not revealed and confidentiality still applies.

**PROCESS OF THERAPY**

Our first few sessions will involve an evaluation of your child’s needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include if you decide to continue with therapy. During these evaluation sessions, you should also be considering whether you feel comfortable working with me. At the end of the evaluation, I will also notify you if I believe that I am not the right therapist for you or if I believe your child can benefit from a treatment that I do not provide.

Therapy involves a large commitment of time, money, and energy, so it is important you feel comfortable about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. Various mental health professionals work from differing perspectives and you have the right to seek another opinion at any time. If you do not feel comfortable working with me or if I believe another practitioner would be better suited to help you, I can help you find another therapist.

# Length of Treatment

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services your child needs in order to meet his/her treatment goals. If we agree to begin psychotherapy, I will usually schedule one [45-minute] session (one appointment hour of [45] minutes duration) per week, at a time we agree on, although some sessions may be longer or more frequent.

**DISCOUNTINUING THERAPY**

Your participation in therapy is voluntary and you are free to discontinue at any time. However, because difficult feelings often arise in therapy and sometimes contribute to the consideration to end treatment, I encourage you to talk with me about the reason for your decision and to allow us to bring sufficient closure to our work together. During the course of therapy, if I see that we are not making progress towards treatment goals we will discuss this along with termination. We can also discuss any referrals you may need at that time.

# PROFESSIONAL FEES

My hourly fee is $130 for each 45 minute session, which includes the fee for meetings with caregivers as well. If we meet more than the usual time, I will charge accordingly. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations, travelling to and attending meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me.

If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. [I charge $300 per hour for professional services I am asked or required to perform in relation to your legal matter.]

# BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. Payment may be made by cash, check, or credit card. Payment schedules for other professional services will be agreed to when such services are requested. If a credit card is used for payments, I will ask you to sign a Credit Card Authorization Form. If a payment is not made when services are provided or there is a late cancellation (less than 48 hours beyond the 2 cancellation limit), I will charge the credit card for the required payment.

If you are having difficulties making your payments for therapy please notify me and we can discuss options. I do not allow clients to carry balances. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information I will release regarding a patient’s treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

**CANCELLATIONS, LATE ARRIVALS, AND NO-SHOWS**

I require a 48-hour notice to cancel sessions without charge. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours [2 days] advance notice of cancellation. I understand that things can come up and therefore allow a total of 2 canceled sessions each year without charge. After those 2 cancellations, you will be charged the full session fee for the missed session. Once we have decided to work together on a regular basis, I hold the appointment time for you; I cannot give it away to others. If you are able to give me notice, I will make every effort to offer you another time during the week so as to maintain the continuity of therapy. If we’re both able to reschedule your appointment during the week, you will not be charged for the missed session. If you are 15 or more minutes late and have not contacted me, I will assume you are not coming to the session and it will be considered a cancellation for which you will be charged the full fee.

# INSURANCE

I do not participate in any health insurance plans or panels. Some insurance plans reimburse for some portion of psychotherapy. Please direct questions about reimbursement amounts and timeliness to your insurance company, as some issues and therapy interventions are not covered. I am not contracted (in network, preferred provider) with any insurer. I can provide you with a receipt for the therapy services at your appointment that may be used to submit for reimbursements if you choose. This information may include diagnostic codes, procedure codes, therapy dates and times, charges, and payments made. Once this information is provided to an outside agency, I have no control over how it is used so please consider this before choosing to release this information. Please note that I do not complete any insurance paperwork and it is your responsibility to obtain information regarding reimbursements from your insurance company.

# CONTACTING ME

I am often not immediately available by telephone. Even during office hours, I probably will not answer the phone when I am with a patient. The best way to contact me is by phone at (916) 545-0643. Messages can be left on this number at any time. I check my voicemail throughout business hours and make every effort to return calls within 24 hours, with the exception of weekends, holidays, and vacation time. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact the nearest emergency room, your primary care physician, the Sacramento County 24-hour crisis line (888) 881-4881, or 911.

**EMERGENCIES**

Although you can leave me a message at any time, I am often not immediately available. If you have an emergency requiring immediate attention, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. In the Sacramento the crisis line may be reached 24 hours a day at (888) 881-4881. You may also call 911. If I will be unavailable for an extended time, another therapist will provide coverage, and at that time, their name and contact information will be provided to you.

**ELECTRONIC COMMUNICATION**

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

**EMAIL COMMUNICATION**

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments. Please do not email me about clinical matters because email is not completely secure or confidential. Be aware that email and other forms of electronic communication, in their typical form, are not confidential means of communication. In addition, all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet Service Provider. In addition, there is a reasonable chance others may intercept and read these messages including people in your home environment with access to electronic devices you use or your employer if you use your work email to communicate with me. Any emails I receive from you and any responses that I send to you also become a part of your legal record. If you need to discuss a clinical matter with me, please bring it with you to your therapy session, as the face-to-face context simply is much more secure as a mode of communication.

**TEXT MESSAGING**

Because text messaging is a very unsecure and impersonal mode of communication, I will only use text messaging to set or change appointments. Please do not text message me regarding clinical matters or to communicate any other information, as phone call and in-person are the only means by which I will respond to this information.

**SOCIAL MEDIA**

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

**WEBSITES**

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

**WEB SEARCHES**

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

Child/AdolescentPatient:

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor’s Signature\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child’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 may have the 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 child’s/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, unless otherwise noted above. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

I consent to receiving text messages and email to set or change appointments and understand these means of communication will only be used for these purposes. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_

\* For young children, the child’s signature is not necessary