RISE CENTER FOR PSYCHOLOGY

INFORMED CONSENT (MINOR)

PARENT AUTHORIZATION: I am very pleased to have the opportunity to work with you. This document contains very important information about my policies and by initialing/signing below, it will represent an agreement between us. 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 might 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 the 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, please keep in mind that your child's therapeutic progress is the ultimate goal. Ultimately however, 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, if it comes to that, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

Initials: Parent(s) _____

COMMUNICATION: At some point in the beginning treatment, I typically meet with you and your spouse together, or some variation if there is a parental separation or divorce. Please note that at all times, my client 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.

Initials: Parent(s) _____

PAYMENT: My fees will be discussed privately with you, either prior to, or during, our first appointment. Payment in full is expected at the time of service, or according to a mutually agreed upon schedule with me. In addition to weekly appointments, I charge for other professional services you may need, such as report writing, telephone conversations, email dialogues, attendance at meetings with other professionals that you have authorized, preparation of records or treatment summaries, and time spent performing any other service you may request. Your account is expected to be paid in full at the end of each month. Most health insurance policies will cover some portion of mental health treatment. I do not participate as an "in-network" provider. I will be happy to help you understand any questions you may have regarding your insurance policy; however, I do not submit bills to insurance companies, and you (not your insurance company) are responsible for full payment of my fees.

Initials: Parent(s) _____

CANCELLATION POLICY: Once an appointment is scheduled, I have a strict 24-hour notice for cancellation. This reasonable prior notice of cancellations permits me to better accommodate my other clients' needs. Except in cases of family/medical emergency and illness, appointments cancelled within 24 hours will be charged full fee for the appointment. These fees are not covered by health insurance and are the client's personal responsibility.

Initials: Parent(s) _____

CONFIDENTIALITY: Confidentiality is your right and our duty. In general, the privacy of all communications between a client and a psychologist is protected by law, and I can only release information about our work to others with your written permission. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order. The privacy of all records pertaining to your treatment will be maintained securely by us. Records will be kept for a minimum of seven (7) years, will be used only for appropriate treatment purposes, and will be released only with your specific written consent or authorization, as provided for by Illinois and Federal law. You have the right to review your records (including the record of disclosures made) upon your written request. I charge a reasonable fee for copying records requested by you. If at any time you feel your privacy has been violated, you have the right to file a grievance with me and/or with the Secretary of the U.S. Department of Health and Human Services. Note, however, that the law requires the release of otherwise confidential information when the provider reasonably believes disclosure is necessary to protect against harm to yourself or others, when there is suspicion of child or elder abuse, and when records are demanded by Court Order. Specifically, as it relates to "minor clients," confidentiality cannot be maintained when child clients tell me they plan to cause serious harm to themselves or others, or that if I am told, or suspect, 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 [may be] required by law to report the alleged abuse to the appropriate state child-protective agency. Confidentiality cannot be maintained if I am court ordered to disclose information.

Initials: Parent(s) _____

DISCLOSURE OF MINOR'S TREATMENT INFORMATION TO PARENTS: Therapy is most effective when a trusting relationship exists between the psychologist and the client. 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 they 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.

DISCLOSURE OF MINOR'S TREATMENT INFORMATION TO PARENTS (cont.): 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. 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. Although the laws of Illinois 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 teenager 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. **Initials: Parent(s)** _____

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 my hourly rate for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs. **Initials: Parent(s)** _____

SIGNATURES:

Child/Adolescent Client: 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** _____

Parents/Guardians 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. **mom**_____**dad**_____

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. **mom**_____**dad**_____

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. **mom**_____**dad**_____

Parent/Guardian Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

THANK YOU/NEWSLETTER: If you have any questions, please do not hesitate to ask. Also, *please let me know if you would like to be added to our monthly newsletter by adding your email(s) below.* Thank you.

Email: _____ Email: _____