Parental Consent to Treatment Form

This office requires all parents who have legal custody of a minor to sign our consent for treatment form for treatment to proceed. Thank you.

Office Policies and Financial Contract with Consent for Treatment

We want your psychological needs to get the best and most efficient attention possible. A sound relationship between patient and therapist is based on a mutual understanding of these general office policies.

Treatment Philosophy

Outpatient psychotherapy consists of face-to-face contacts between a licensed professional and patient, and may include individual, group, family therapy, crisis intervention, medication consultation, short or long term therapy. If your contract is with managed care, brief therapy directed and problem focused. You will be expected to participate in setting and achieving treatment goals. A case manager at the managed care company manages the number of sessions, and information about your therapy will be requested. You will be asked to sign a release of confidential information for that purpose.

Attendance and Cancellation Notice

Regular attendance is necessary to receive the maximum benefit possible from treatment. Appointments are normally 45 minutes and this time is reserved for you. It is customary and reasonable to require that you give a 24-hour notice for a cancellation of a scheduled appointment. The responsible party (the parent bringing the child) will be held liable for the full contracted rate of **$ 95.00** for broken appointments not canceled with a 24-hour notice. Managed care and insurance companies cannot be billed for these broken appointments. A pattern of failure to keep appointments or a pattern to not give 24-hour notice to cancel may be terms for the insurance or managed care company to disallow treatment.

Financial Contract, Deductibles, and Co-payments

The parent bringing the child is responsible for obtaining prior authorization from insurance or managed care company prior to treatment. If this office accepts your insurance or we are a contracted provider for your care company, the responsible parent is responsible for the co-payment amount and the deductible as set by your benefit plan.

If this office is a contracted provider for your managed care plan, we are obligated to accept from you the pre-arranged co-payment only and you are not obligated for the above contracted rate, the exception being for “no show” or broken appointments where there has not been given a 24 hour notice.

Co-payment amounts are set by your benefit plan. These payments are due and payable at the beginning of each appointment. If you desire services not provided by your managed care company or benefits beyond your benefit contract, you will need to sign a separate written contract with this office. (Please initial______).

Telephone Calls

We take seriously our duty to return telephone calls. If there should occur a time where essential concerns must be discussed on the telephone, the Dr. charges at the same rate as the contracted rate above, based on the amount of time on the telephone. These charges will be your personal expense if they cannot be billed to your insurance company, as they most often cannot. (Please initial______).

Limits Of Confidentiality

All information and records obtained during the course of treatment shall remain confidential and will not be released without written consent signed by you. The legal exceptions to your confidentiality are listed below:

(1.) If a therapist believes that a patient intends to eminently commit serious bodily harm to another identifiable person or persons, it is the therapist's duty to warn the person or persons of intended harm as well as the authorities (Tarassoff vs. Regents of University of Cal., 1976).

(2.) If a therapist believes that a patient intends to eminently commit serious bodily harm to himself, it is the therapist's duty to take necessary action to protect the individual, which may include notifying authorities (Johnson v. County of Los Angeles, 1983).

(3.) If a patient becomes involved in certain kinds of very important court cases, a judge may subpoena records and/or testimony. This is rare, but the therapist's ability to shield confidentiality in these cases may be compromised and varies from case-to-case.

(4.) If a therapist suspects that a child, elder, or dependent adult either is currently being abused, or has been abused in the past (where there is a risk of re-offense), and the authorities don't already know about it, it is the therapist's duty to inform the authorities (Welfare & Institution Codes, Penal Codes Section 11165, 11166 and others).

Releases of Information

Certain insurance companies (Medicare) and managed care companies ask us to get a release to the primary care physician to coordinate care. You may refuse this request or you can allow it. You will be asked if you wish to sign a release of confidentiality form.

If you are electing to use your insurance or managed care benefits, you will be required to sign a release of confidential information to your benefit plan so as to process claims, for certification, case management, quality assurance, benefit administration and other purposes such as utilization. If you do not want such information to be shared with your benefit plan, you may pay privately without using your insurance company.

Consent for Treatment

I authorize and consent to treatment, which may include various psychological assessment techniques, psychological exams, diagnostic procedures, and psychotherapeutic services. I understand that while psychotherapy is intended to be helpful, no guarantees as to outcome can be made. The psychotherapeutic process can cause a person to experience unpleasant emotions, feelings and reactions such as anxiety, sadness, and anger. These responses are normal, if they should occur, and I agree to work through these responses with my therapist.

I accept and consent to the office policies, financial arrangements, as well as the terms of each of the foregoing paragraphs of this contract.

Patient Name ___________________________________

Parent Signature ___________________________________ Date ______/______/______

Parent Name ___________________________________
(print)

Therapist Signature ___________________________________ Date ______/______/______