Consent for Treatment of Minors

This agreement has been created to outline the terms and conditions of services to be provided by Suzanne Gorter, MFT for the minor child(ren)_____ and is intended to provide_____with important information regarding the practices, policies, and procedures of Suzanne Gorter, MFT, and to clarify the terms of the professional therapeutic relationship between Therapist and Client. Do not hesitate to discuss any questions or concerns that you have with the content of this agreement prior to signing.

Treatment of Minors: Children and adolescents benefit most from psychotherapy when their parents, guardians, or caregivers are supportive of the process. It is important for the therapist and child or adolescent to establish a trusting relationship in which the client can express and explore feelings associated with the issues that have brought him or her into treatment. To this end, the details of discussion with your child will be kept confidential. Be assured that you will be kept up to date as to progress of therapy and informed in the event of any serious concerns that I might have regarding the safety or well being of your child, including the risk of harming themselves or someone else.

Additionally, it is beneficial to have the consent of both parents before beginning treatment. If there is a question in cases of shared custody about the authority of one parent to give consent for treatment, I will ask for a copy of legal documentation, such as the custody order prior to treatment. In some cases a third party signature, such as a social worker, may be required before treatment can begin.

Please be prepared to wait while your child is in his or her therapy session. It is important to have a parent or guardian available should they be needed during that time. Encourage your child to use the restroom prior to therapy. Should your child require help in the restroom, I will ask you to attend to that task.

Treatment options for your child include attachment-based therapy which would involve parent(s) and child together in session, individual play therapy, or traditional talk therapy depending on the child's issues, age, and interest. Together we will discuss your concerns regarding your child and determine the best course of treatment. Depending on the age and developmental stage of your child, it may or may not be appropriate for him or her participate in treatment planning.

In the event that your family engages in attachment-based therapy, hands on therapeutic touch is sometimes used. Examples of this are assisting child in taking off/putting on shoes, holding hands, standing back to back, or a hand on the child's arm. Many times these techniques will be

demonstrated by the therapist, and then the parent will continue with the activity. I will always ask permission before utilizing such interventions and respect the client's response.

Risks and Benefits: Psychotherapy is a process in which we explore many issues, events, experiences, and memories for the purpose of creating positive change so that your child can achieve healing and experience life in positive ways. A child often reacts to therapy in nonverbal ways. Outside of therapy, he or she may appear calmer, more cooperative, and settled. He or she may also become more easily agitated, frustrated, or seem sad. Your child may be unable or unwilling to articulate their feelings, so asking them to do so may frustrate both you and them. You can best support your child by providing a consistent, familiar routine, providing extra nurturing when appropriate, maintaining limits and boundaries when needed, and letting your child know that you are available for extra support. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. While there is no guarantee of what your child will experience, the goal and hope is that working together we will achieve the goals and benefits that are desired.

Confidentiality: Confidentiality is essential to the therapeutic process. The privacy of all communication between a client and therapist is protected by law. I cannot tell anyone else that you are a client, what is said in therapy, or release any information about our work together without a signed release of information from you. There are some important exceptions to confidentiality. As a mandated reporter I am legally obligated to report the following situations.

1. Child Abuse-If I have reason to suspect that a child is being abused or neglected, I must make a report to the appropriate agency.
2. Elder and Dependent Adult Abuse-If I have reason to suspect that an adult over 65 or a dependent adult aged 18-64 is being abused, I am required to report to the appropriate agency.
3. Intent to Harm –If you report your intent to harm another individual, I am required to take protective actions which may include informing law enforcement and the intended victim.
4. Suicidality-I am legally allowed to break confidentiality in order to take protective measures if I believe you are in danger of harming yourself. These may include contacting family members or others who can provide protection or to seek hospitalization for you.
5. Insurance Providers-I will provide third-party payers requested information regarding services. These include, but are not limited to: types of service, dates/times of service, diagnosis, treatment plan, and progress of therapy.

I have read and understand these limits to confidentiality_____.

Client's Initials

Therapist-Client Privilege: Information disclosed by you, the client, as well as my records are subject to the Therapist-Client privilege. This privilege is established by law to recognize the special relationship between a client and therapist, similar to doctor-patient privilege. Typically the client is the holder of the privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the Therapist-Client privilege on your behalf until instructed, in writing, to do otherwise by you or by your representative. When the client is a minor, the holder of the Therapist-Client privilege is either the minor, a court appointed guardian, or minor's counsel. Parents typically do not have the authority to waive the Therapist-Client privilege for their minor children

unless given such authority by a court of law. If you have questions or concerns regarding the Therapist-Client privilege, please address them with your attorney.

Record Keeping: I am required by law to keep treatment records. These records are the sole property of the therapist. If you should request a copy of your child's records, the request must be made in writing. I reserve the right, under California law, to provide a summary in lieu of actual records. I will keep records for ten years following the end of therapy, or when the client has turned 21, whichever is longer. At that time they will be destroyed in a manner that preserves client confidentiality.

Fees: My usual and customary fee for services is $120.00 per session. Children's sessions typically last from 35-45 minutes. I reserve the right to adjust this fee periodically and will notify you in advance if this fee is adjusted. This fee may also be adjusted by contract with insurance, managed care organizations, other third party payers, or by agreement with the therapist.

The agreed upon fee for your sessions is $_____. Payment is due at the beginning of each session, unless we have made other arrangements and can be made by cash, check, or credit card.

From time to time you and I may have telephone conversations for purposes other than scheduling and I may have telephone conversations with third parties at your request and with prior written authorization. You are responsible for payment of phone calls longer than 15 minutes, prorated on our agreed upon fee.

Insurance: I am a contracted provider with a limited number of insurance carriers a managed care organization. By signing this consent you are also agreeing to information to be shared with the insurance companies necessary to the billing process. Should you choose to use insurance for which I am not a contracted provider, I will provide you with a statement which you can submit to your insurance company to seek reimbursement of fees already paid. My services would be considered "out of network" provider services. It is your responsibility to verify and understand the limits of your coverage, as well as your co-payments and deductibles.

Cancellation Policy: Your child's regular attendance to the therapy appointment is part of your commitment to the psychotherapy process. Sessions are typically scheduled on a consistent day and time, which is then set aside for your child as my commitment to that process. A minimum of 24 hours notice is required for rescheduling or cancellation of an appointment, with the exception of valid emergencies or illness. Payment of our agreed upon fee is required for appointments missed without notification.

Telephone and Emergency Procedures: You can reach me by calling 805-235-5407. I check my voicemail throughout the day and will make every effort to contact you within 24 hours or by the next business day. I will arrange for telephone coverage by a qualified therapist if I am out of town. I am unable to provide 24-hour crisis service. In the event that you are feeling unsafe or you require immediate medical or psychological assistance, call 911, Hotline at 783-0607, or go to the nearest Emergency room.

Termination: I reserve the right to terminate therapy for reasons that include, but are not limited to: failure to follow treatment recommendations, failure to participate in therapy, non or sporadic attendance, if you have missed 3 consecutive appointments without notification, conflict of interest,

or if your issues are out of my scope of competence or practice. If either you or I decide to terminate therapy, I will generally recommend that we have at least one, possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and to reflect on the work that has been done. I will also attempt a smooth transition to another therapist by offering referrals to other therapists in the area.

Acknowledgement: I have read this statement, asked any questions that I have regarding its content, and understand it. I agree to abide by the terms and conditions of this agreement and consent to treatment by Suzanne Gorter, MFT. I agree to hold Suzanne Gorter, MFT, free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that my result from such treatment.

_____

Client Name-if over 12 yrs old (please print)

_____ _____

Client Signature-if over 12 yrs old *Date*

_____

Name of Parent or Guardian (please print)

_____ _____

Signature of Parent or Guardian (or authorized representative) *Date*

_____

Name of Parent or Guardian (please print)

_____ _____

Signature of Parent or Guardian (or authorized representative) *Date*