MELBOURNE
INTEGRATIVE PSYCHOLOGY
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## *Informed Consent for Treatment of Children and Adolescents*

Before you start counseling for your child, there are some things you ought to know. Legally, this is called "Informed Consent." Informed consent will help you understand what to expect from your child's therapy, and it will explain some limitations to what we will be doing here.

Name of Child or Adolescent _____
Age _____ Date of Birth _____ Phone Number _____

Custodial Parent(s) or Legal Guardian's Name:
_____

## *Confidentiality*

Psychotherapy with people of any age relies on the client's confidence that what is shared with the therapist is private and confidential. In general, all information provided to a therapist (e.g. conversations, treatment records) is protected by something called privilege. As the parent or guardian you are the holder of privilege for your child's treatment. That means that the law protects you from having information about your child given to anyone without your awareness and permission. Our office respects your privacy and we intend to honor your privilege. However, there are some exceptions that you should understand before we start.

If we believe that there is a risk that your child might harm his or herself or someone else, we may be required to contact the authorities or the other person to give them the opportunity to protect your child or someone else. If we have reason to believe that your child is being abused, we are required by law to notify the authorities, so they can protect your child from harm. Also, if you become involved in any lawsuit in which your child's mental health is an issue--for example, a child custody dispute or an injury lawsuit in which you claim compensation for emotional pain and suffering—then the court or lawyers may insist upon, and may obtain your child's information from us.

**Please note that Dr. Donaldson does not testify in court proceedings.** By signing this document you agree that if Dr. Donaldson is called to testify in court it would be damaging to the child's therapy and is not in the child's best interest. If a complaint is filed by you against our office, you would also lose the protection of your privilege.

The financial part of our relationship also imposes some confidentiality limits. If you are using insurance or another third party payer, our office must share certain information with them, including (but not necessarily limited to) your child's diagnosis and the dates of office visits. If there is a managed care company, they may require us to provide additional information, such as your child's symptoms and progress. You should also understand that insurance and managed care information is often stored in national computer databases.

## *Our Office Policies*

We schedule appointments to begin on the hour or half-hour. Counseling sessions usually last 45-50 minutes, and we must end each session promptly. Unless other arrangements have been made, payment is due at the time of your appointment. We can accept cash, checks, or credit cards for your payment. Our office may charge a full fee even if you are late, or you cannot make your appointment and do not cancel the appointment 24 hours in advance. Your insurance will not pay for missed sessions, you must pay for those yourself. Our office charges a $30 fee for a returned check.

Our telephone is answered 24 hours a day by a confidential voice mail system. Through the day, we check messages regularly, and whenever possible we try to return phone calls the same day. If we have not returned your phone call within 24 hours, please try again as your message may have been lost. We do not check office messages after 6:30 p.m. on weekdays, or routinely on weekends. If you have an emergency after 6:30 p.m. or on a weekend, call 911, or go to the Emergency Room at your nearest hospital.

When we are out of the office for several days, we will be available through email or cell phone for emergencies. To the extent possible we will keep you informed about when we are away from the office and when we will return.

By my signature below, I certify that I am the parent with the authority to consent to treatment for this child and that I understand the conditions outlined in this consent form.

_____ _____ _____ _____

Parent/Guardian Signature Date Therapist Signature Date