Sarah Kelley, M.S., LMFT
Individual, Family, and Child Therapy
1801 E. Parkcourt Pl., Ste. D103
Santa Ana, CA 92701
(714) 271-3643
Sarah@sarahkelleytherapy.com

Informed Consent-Child

This form reviews office policies and procedures and explains the therapeutic relationship between_____ and Sarah Kelley, M.S., LMFT. Please ask any questions before signing. By signing, you agree to the content of this form.

Introduction

I am a Licensed Marriage and Family Therapist (LMFT#83792). I have a Master of Science in Counseling. I am certified by the Board of Behavioral Sciences (BBS). I appreciate the opportunity to serve your child and you. This document contains important information about my professional services and business policies.

Understanding the Therapeutic Process: Therapy, whether for adults, teens or children, is most effective when family members and the therapist make a commitment to the therapeutic process. Our first few sessions will involve an evaluation of your child or teen's needs, from which I will provide impressions of what our work will include and an initial treatment plan. Ideally, the therapy office becomes a safe and private place for the child or teen client to explore--through art, play and conversation--feelings, beliefs and challenges. This is best accomplished when a confidential relationship exists between the young person and the therapist (see *Confidentiality with Minors* section below).

Your Role as a Parent: As the most powerful and influential figures in a child's life, parents must be willing to explore their own challenges and make any necessary changes to help their child heal. Positive change in families becomes possible when parents foster an atmosphere of mutual respect, curiosity and compassion. Depending upon the age of your child and the issues involved, I will ask you to attend part or all of some therapy sessions, and to practice the skills learned in therapy at home with your child.

Psychotherapy has Both Risks and Benefits: As with any effort to create lasting change, psychotherapy requires time, energy and commitment. Psychotherapy can feel frustrating because we often cannot control the pace of change. On the path toward healing, clients may experience an increase in painful feelings; this is a normal part of the process. Usually people find psychotherapy helpful, although it can cause disappointing or unexpected outcomes. If you have concerns about your child's progress or any aspects of treatment, I invite you to discuss this with me in person or in writing. You are free to terminate at any time; however, I hope you will discuss this prior to stopping. I can give you a referral to other providers if you choose to discontinue our work together.

Services to a Minor Client: If the client is a minor, the parent/guardian has the right to refuse treatment for the minor. It is my policy to generally obtain consent from both legal

parents/guardians for services to a minor. Should one parent actively deny consent to treatment, I generally will not provide treatment services. Even in the situation of divorce or where one parent seeks and pays for treatment, the other legal parent has a right to consent/deny treatment and has full access to their child's records (unless these rights are waived as described below).

Please indicate (initial below) if the other parent/guardian, with legal parenting rights, does not have knowledge of, or has disagreed with, therapy for this child _____ (print your initials, or write N/A if Not Applicable).

If not, may I contact him/her? yes/no Name:_____ Phone: _____

Confidentiality with Minors: A parent or legal guardian is considered the client for the purposes of treatment decisions and permitting release of information. It is my policy to request an agreement from parents/guardians that they consent to give up access to their child's records. If they agree, I will only provide them with general information about their child's work with me, unless I believe their child is in immediate danger of harm to their life, health, safety, or severe legal problems. The parent/guardian should clearly tell me of any specific matters about which they wish to be informed. Unless stated otherwise, minors and parents are hereby informed that I will use my professional judgment to determine when confidential information provided by a minor is shared with a parent/guardian. If the minor is granted this privilege, all records will be safeguarded, even from parents/guardians.

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice. As such, the therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, the therapist will not reveal any personally identifying information regarding the client.

Records and Record Keeping

The therapist may take notes during session, and will also produce other notes and records regarding the client(s)' treatment. These notes constitute the therapist's clinical and business records, which by law, the therapist is required to maintain. Such records are the sole property of the therapist. The therapist will not alter her normal record keeping process at the request of any patient. If the client requests a copy of the therapist's records, it must be done in writing. The therapist reserves the right, under California law, to provide the client with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. The therapist will maintain the client(s) records for 7 years following termination of therapy. However, after 7 years the client(s)' records will be destroyed in a manner that preserves the client(s)' confidentiality.

Confidentiality

The information disclosed by the client is generally confidential and will not be released to any third party without written authorization from the client, except where required or permitted by law.

Exceptions to confidentiality include: 1) Child, elder and dependent adult abuse 2) When a

client makes a serious threat of violence towards a reasonably identifiable victim 3) When a patient is dangerous to him/herself (e.g. suicidal) or the person or property of another 4) Knowledgeable viewing of child pornography

Fee and Fee Arrangements

The agreed upon fee between the therapist and client(s) for service is _____ per _____minute session. Clients are expected to pay for services at the time services are rendered. The therapist accepts cash, checks, and major credit cards. Sessions longer than scheduled time are charged at an additional, pro-rated fee in 15-minute increments. Therapist reserves the right to periodically adjust this fee. Patient will be notified of any fee adjustment in advance.

Insurance

The client is responsible for any and all fees not reimbursed by his/her insurance company. The client is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles. The therapist is an out of network provider. The therapist is not a contracted provider with any insurance company. The therapist will provide the client(s) with a statement, which the client can submit to his/her insurance company to seek reimbursement of fees already paid. If the client intends to use benefits of his/her health insurance policy, the client agrees to inform the therapist in advance.

Patient Litigation

The therapist will not voluntarily participate in any litigation, or custody dispute in which the client(s) and another individual, or entity, are parties. The therapist has a policy of not communicating with the client(s)' attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in the client(s)' legal matter. The therapist will generally not provide records or testimony unless compelled to do so. Should the therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving the client(s), the client agrees to reimburse the therapist for any time spent for preparation, travel, or other time in which the therapist has made herself available for such an appearance at the therapist's usual and customary hourly rate.

Therapist-Client Privilege

The information disclosed by the client(s), as well as any records created, is subject to the psychotherapist-client privilege. The therapist-client privilege results from the special relationship between the therapist and the client(s) in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the therapist-client privilege. If the therapist received a subpoena for records, deposition testimony, or testimony in a court of law, the therapist will assert the therapist-client privilege on the client's behalf until instructed, in writing, to do otherwise by the client or the client's representative. The client should be aware that he/she might be waiving the psychotherapist-client privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. The client should address any concerns he/she might have regarding the psychotherapist-client privilege with his/her attorney.

Cancelation Policy

The client is responsible for payment of the agreed upon fee for any missed session(s). The client is also responsible for payment of the agreed upon fee for any session(s) for which the client failed to give the therapist at least 24 hours notice of cancellation. Cancellation should be left on the therapist's voice mail at: **(714) 271-3643**

Phone/E-mail

The therapist has a confidential voice mail system. The therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. The therapist is unable to provide 24-hour crisis service. In the event that the client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

You can reach me through email at: **sarah@sarahkelleytherapy.com**. Email is not guaranteed to be confidential. The client uses email at his/her own risk. If you choose to email, keep correspondence to scheduling and avoid sharing confidential information.

Termination of Therapy

The therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to: failure to pay fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, if client's needs are outside of the therapist's scope of competence or practice, or the client is not making adequate progress in therapy. The client has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, the therapist will generally recommend that the client participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. The therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to the client.

Acknowledgement

By signing below, the client acknowledges that he/she has reviewed and fully understands the terms and conditions of this agreement. The client has discussed such terms and conditions with the therapist, and has had any questions with regard to its terms and conditions answered to the client's satisfaction. The client agrees to abide by the terms and conditions of this agreement and consents to participate in psychotherapy with the therapist. Moreover, the client agrees to hold the therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

I understand that I am financially responsible to the therapist for all charges, including unpaid charges by my insurance company.

_____ _____

Patient Name/Representative (please print) Date

_____

Signature of Patient (or authorized representative)