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INFORMATION FOR MINOR CLIENTS AND CONSENT FOR TREATMENT

Client information:

Name: _____

Date of Birth: _____

Parent/Guardian: _____

About Therapy

Therapy is a partnership between client and therapist. You define your concerns and we work together to establish therapy goals. Ongoing treatment requires your active participation and regular attendance. Therapy can be hard work and may be uncomfortable at times. Through exploring your experiences, thoughts, and feelings, therapy can help to achieve your goals. Therapy may enable and empower you to make changes in your patterns of thinking and behaving. In family therapy, family members have the opportunity to effectively communicate with one another and to improve relationships.

Miscellaneous

I am an independent practitioner; shared office space does not imply partnership. Parents bringing their children for therapy agree not to enlist my involvement in child custody/visitation related matters or legal proceedings associated with custody and visitation decisions. Furthermore, I will not testify in court about child custody or visitation as these issues require specific protocols, including investigations and evaluations, which we will not be doing. Additionally, involvement in such matters poses a risk to therapeutic progress.

Records

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging or injurious to your health, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. Records are kept electronically with a secure program designed specifically for psychotherapy practices.

Confidentiality

Information that you discuss in therapy is confidential. I will not reveal to anyone that you are receiving services from me, unless I have your written permission. For example, with your written permission I may provide a diagnosis, treatment plan or summary. There are several situations in which confidentiality may be breached or I am legally obligated to report or take action:

- If testimony is required by a judge for certain judicial or criminal proceedings
- If abuse or neglect of a minor is suspected (I will make every effort to discuss the matter with you before I make a report, unless I judge that there is imminent danger that someone will be harmed.)
- Emergency situations such as:
    1) If a client threatens to harm him/herself or another person
    2) If a client is in danger due to extremely severe symptoms (e.g., severe depression, psychosis)

If there is an emergency while you are in therapy, please list a person whom you authorize me to contact:

Name: _____

Relationship: _____

Phone: _____

Address: _____

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

If I die or become incapacitated, my Professional Executor (a licensed mental health professional) may take control of records and contact clients.

If a client is less than 18 years of age, the legal guardian or parent has access to the records. If documentation is needed, the parent agrees to accept a summary of treatment notes instead of exact treatment notes in order to safeguard the child's confidentiality and willingness to be forthcoming within sessions. We will discuss a more specific plan for informing parents/guardians about treatment progress during the initial session. My policy is to have parents waive their right to access their child's information, and for me to have discretion in what I share with them about therapy.

If you have questions about confidentiality, I will be happy to discuss them with you. If there are legal

issues involved, it may be necessary for you to seek legal advice.

Outside of Session Contact

You can leave a message on voice-mail at any time. I retrieve my messages frequently and generally return calls within 48 hours. On weekends and holidays, phone calls may not be returned until the next business day. If you have an emergency and cannot reach me immediately by telephone, go to the nearest hospital emergency room. If needed, here are emergency hotline numbers: Montgomery County Crisis Center (crisis intervention) at 240-777-4000, Montgomery County Hotline (supportive listening) at 301-738-2255, 1-800-273-TALK (suicide hotline), or text 741741 (suicide text line).

Please do not use text messaging or e-mail to convey urgent information. Although Dr. Frank uses encrypted email, please be aware that e-mail and text messaging are subject to breaches in confidentiality.

- ☐ Yes, I would like to communicate clinical and private information that is not urgent via email and/or text.
- ☐ Yes, I would like to communicate general information that is not clinical and not urgent via email and/or text.
- ☐ No, I would not like to communicate via email.

About Fees, Payments, and Billing

Therapy services (family, marital, or individual therapy): For a 45-minute session, the fee is $200. The fee for a 55-minute session is $210. The initial session cost is $250 and may include gathering information from various sources. You can pay with check, cash or credit card. Silver Spring Counseling and Associates, including, Dr. Frank, does not participate with insurance. You should carefully read the section in your insurance coverage booklet that describes mental health services with out of network providers. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. I am not a participating provider on your health plan, you will be responsible for the session fee and I will provide the necessary paperwork to submit to your insurance. You are responsible for notifying me about pre-authorization or treatment plans which are due. Payment is due monthly.

Other services: Charges for other services (such as school consultations and consultations with lawyers) are $250 per hour. These charges are not billable to insurance. There will not be a fee for brief telephone contact (< 15 minutes) with the client or other professionals involved with the client. Longer telephone contact (>15 minutes) will be charged at the hourly rate for therapy ($210 per hour). I discourage requests for me to testify in court about your therapy because it can put significant strain on the client-therapist relationship and compromise therapeutic progress. If there are extenuating circumstances and I need to testify, there is a charge of $350 per hour to be paid before testimony is

provided.

Missed sessions or cancellations: If you are unable to keep an appointment, please let me know at least 2 days in advance. Without such advance notice, you will be charged $100 for the missed session. Please note that I cannot bill your insurance company for a missed session and you will be responsible for the fee. If there is inclement weather, please call me at 301-455-8825 to discuss if the office is open. If there is any problem with billing or paying the fees, please bring it to my attention. Such problems can interfere with our work, so they must be resolved openly and quickly.

Billing Arrangement

You (parent/guardian) are responsible for payment even if the insurance company denies the claim. If there is an outstanding balance for more than 3 months, I reserve the right to submit the debt to a collection agency or file in small claims court. Any collection fees and related expenses will be billed to you.

Parent/Guardian Signature Date

Treatment Agreement

Consent parents/caregivers: You have read this brochure and understand its contents. You have had the opportunity to read the Notices of Privacy Practices. Any of these materials are available upon request. You agree to allow your child to participate in psychotherapy and pay the fees associated with these services.

Parent/Guardian Signature Date