INFORMED CONSENT FOR ADOLESCENT PSYCHOTHERAPY

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the *Health Insurance Portability and Accountability Act (HIPAA)*, a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. **When you sign this document, it will represent an agreement between us.** We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

The purpose of meeting with a therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a therapist about these problems. Or, you may be here because your parent, guardian, doctor, or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you, and work together to identify a plan in addressing these problems. It is important for me that you feel safe and comfortable in talking with me about the issues that are bothering you. Sometimes these issues will include things you do not want your parents or guardians to know. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their therapist. Privacy, also called confidentiality, is an important and necessary part of therapy.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In these situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed these situations under the Confidentiality section.

Psychotherapy has both benefits and risks. The risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Psychotherapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, and increased skills for managing stress and resolutions to specific problems. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you and your parents/guardian some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will provide you and your parents with a referral(s) to set up a meeting with another mental health professional for a second opinion.

CONFIDENTIALITY

It is my ethical responsibility and professional duty to safeguard you from unauthorized disclosure of information given in our therapeutic relationship. I will not disclose any information about you, or the fact that you are my patient, without your written permission.

However, there are important exceptions to this rule of confidentiality. I may use or disclose records or other information about you without your consent or authorization in the following circumstances:

1. When you tell me of a plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future;
2. When you tell me of a plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future;
3. When you are doing things that could cause serious harm to you or someone else, even if you do not intent to harm yourself or another person;
4. When you tell you are being abused physically, or sexually, or emotionally, or that you have been abused in the past;
5. When you are involved in a court case and a request is made for information about your therapy.

In these above mentioned situations, I must take steps to inform your parent or guardian of what you have told me and how serious I believe the threat to be. I must make sure you are protected from harming yourself or from harming someone you intend to do harm. In situations of abuse, I am required by law to report the abuse to the California Child Protective Services. In a court-related situation, I will not disclose information without your written agreement unless the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

In mental health treatment, the parent or guardian holds the legal privilege regarding release of information.

COMMUNICATING WITH PARENTS OR GUARDIANS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 13 and older, I request an agreement between the patient and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy.

Except for situations such as those mentioned above, I will not tell your parent/guardian specific things you share with me in our private psychotherapy sessions. This includes activities and behavior that your parent/guardian would not approve of, or would be upset by- but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent/guardian.

Even if I have agreed to keep information confidential- to not tell you parent/guardian- I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parent/guardian, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

CONSENT TO PSYCHOTHERAPY & PARENTAL AGREEMENT TO RESPECT PRIVACY

Signing below indicates that you have reviewed the policies described above and understand the limits of confidentiality. You have been provided with a copy of this document and have been given the opportunity to discuss your concerns and need for clarifications. Please remember that you may reopen the conversation at any time during our work together.

_____
Patient's Signature

_____
Patient's Printed Name

Date _____

Parents/Guardian

Indicate a check mark and sign below indicating your agreement to respect your adolescent's privacy:

_____ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in parent collateral sessions to discuss progress or recommendations of my child during treatment.

_____ I understand that I will be informed about situation that could endanger my child.

_____
Parent's Signature

_____
Parent's Printed Name

_____
Date

_____
Parent's Signature

_____
Parent's Printed Name

_____
Date

_____
Psychologist's Signature

_____
Date