

CLIENT AGREEMENT/INFORMED CONSENT FOR MINORS

INTRODUCTION: This Agreement has been created for the purpose of outlining the terms and conditions of services to be provided by Loretta Gordon, MFT for the minor child: _____

_____ (herein "Patient") and is intended to provide [name of parent(s)/legal guardian(s)] _____ (herein "Representative(s)") with important information regarding the practices, policies and procedures of Loretta Gordon, MFT (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

POLICY REGARDING CONSENT FOR TREATMENT OF A MINOR CHILD: Therapy generally requires the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of Representative to give consent for therapy, the Representative will be required to submit supporting legal documentation, such as a custody order, prior to the commencement of services.

EDUCATION AND TRAINING: I have effectively helped individuals gain more choices and build more productive lives since 2000. Prior to my work in private practice I developed my professional skills in various community behavioral settings within San Francisco Department of Public Health and non-profit agencies. I have worked extensively with individuals, adolescents, couples and families. I am a Licensed Marriage & Family Therapist with the State of California (MFT#50459). I have a M.A., Counseling Psychology, Holy Names University, Oakland, California and a B.A., Psychology, University of California, Berkeley, Berkeley, California. My theoretical orientation can be described as primarily cognitive behavioral, however, I integrate complementary methodologies and techniques to offer a highly personalized approach tailored to each client. With compassion and understanding, I work with each individual to help them build on their strengths and attain the personal growth they are committed to accomplishing.

RISKS AND BENEFITS OF THERAPY: A minor patient will benefit most from therapy when his/her parents, guardians or other caregivers are supportive of the therapeutic process. Therapy is a process in which the therapist and client, and sometimes other family members, discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so the individual can experience life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties the individual may be experiencing. Therapy is a joint effort. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Participating in therapy may result in a number of benefits to Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, as well as his/her caregivers and/or family members, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. This discomfort may also extend to other family members, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge the perceptions and assumptions of the Patient or other family members, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Patient should address any concerns he/she has regarding his/her progress in therapy with

Therapist.

RECORDS AND RECORD KEEPING: Therapist may take notes during session, and will also produce other notes and records regarding Patient's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any patient or representative. Should Patient or Representative request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient, or Representative, 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. Representative will generally have the right to access the records regarding Patient. However, this right is subject to certain exceptions set forth in California law. Should Representative request access to Therapist's records, such a request will be responded to in accordance with California law. Therapist will maintain Patient's records for ten years following termination of therapy, or when Patient is 21 years of age, whichever is longer. However, after ten years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

CONFIDENTIALITY: The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another. Representative should be aware that Therapist is not a conduit of information from Patient. Psychotherapy can only be effective if there is a trusting a confidential relationship between Therapist and Patient. Although Representative can expect to be kept up to date as to Patient's progress in therapy, he/she will typically not be privy to detailed discussions between Therapist and Patient. However, Representative can expect to be informed in the event of any serious concerns Therapist might have regarding the safety or well-being of Patient, including suicidality.

PATIENT LITIGATION: Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient, or Representative, and another individual, or entity, are parties. Therapist has a policy of not communicating with Representative's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's, or Representative's, legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Representative agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary hourly rate of \$120 per 50 minute hour. In addition, Therapist will not make any recommendation as to custody or visitation regarding Patient. Therapist will make efforts to be uninvolved in any custody dispute between Patient's parents.

PSYCHOTHERAPIST-PATIENT PRIVILEGE: The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient 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 psychotherapist-patient privilege. If Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by a person with the authority to waive the privilege on Patient's behalf. When a patient is a minor child, the holder of the psychotherapist-patient privilege is either the minor, a court appointed guardian, or minor's counsel. Parents typically do not have the authority to waive the psychotherapist-patient privilege for their minor children, unless given such authority by a court of law. Representative is encouraged to discuss any concerns regarding the psychotherapist-patient privilege with his/her attorney. Patient, or Representative, should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal

proceeding. Patient, or Representative, should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

COUNSELING FEES: The fee per 50 minute individual therapy session is \$120, payable by check, credit card or cash, *due at the beginning of each session*. Sessions longer than 50-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Representative will be notified of any fee adjustment in advance. I offer a limited number of sliding scale slots to clients based on need. To request a reduced fee, please bring proof of household income to your first appointment (pay check stubs, tax statement, etc.) Weekly therapy commitment for 3 months or bi-weekly for 6 months is required to receive *reduced rate*. Therapist is not a contracted provider with any insurance company, managed care organization. Upon request, therapist will provide Representative with a statement or Superbill which Representative can submit to the third-party of his/her choice to seek reimbursement of fees already paid.

From time-to-time, Therapist may engage in telephone contact with Patient or Representative for purposes other than scheduling sessions. Representative is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at the request of Patient or Representative and with the advance written authorization of Patient or Representative. Representative is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. Representative is expected to pay for services at the time services are rendered. Therapist accepts cash, checks.

CANCELLATION OF APPOINTMENTS: If you must cancel your appointment, please call at least **48 hours in advance**. This ensures that I can see people if I have an opening. Cancellation notice should be left on Therapist's voice mail at 510-761-5609. You will be charged a \$75 missed cancellation fee for the time reserved when cancellations are received less than 48 hours in advance, except for emergencies. NSF checks will be assessed a \$30.00 fee. Delinquent accounts are subject to referral to collection agencies and interest at a rate of 10% per annum will apply for balances over 60 days old. Representative is responsible for payment of the agreed upon fee for any missed session(s). Representative is also responsible for payment of the agreed upon fee for any session(s) for which Representative failed to give Therapist at least 48 hours notice of cancellation.

THERAPIST AVAILABILITY: My office is equipped with a confidential voice mail system that allows messages to be left at any time. I 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. I am unable to provide 24-hour crisis service. If you need immediate support, please contact Crisis Support Services of Alameda County 24-hour Crisis Line: (800) 309-2131 or your local crisis line. In the event of a life-threatening situation which requires immediate medical or psychiatric assistance, call 911, or go to the nearest emergency room.

TERMINATION OF THERAPY: Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient or Representative has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient participate in at least one, or possibly more, termination sessions. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient or Representative.

ACKNOWLEDGEMENT: By signing below, Representative acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Representative has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Representative's satisfaction. Representative agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Representative agrees

to hold 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.

Patient Name (please print)

Signature of Patient (if Patient is 12 or older)

Date

Signature of Representative (relationship to Patient)

Date

Signature of Representative (relationship to Patient)

Date

I understand that I am financially responsible to Therapist for all charges. The agreed upon fee between Therapist and Representative is \$_____.

Name of Responsible Party (Please print)

Signature of Responsible Party (relationship to Patient)

Date _____

Name of Responsible Party (Please print)

Signature of Responsible Party (relationship to Patient)

Date _____