

### *Agreement For Service / Informed Consent (Minor)*

First and foremost I want to welcome you to my practice. This document contains important information about my professional services and business policies. Please read it carefully and note any questions you have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

#### **Introduction**

This Agreement has been created to outline the terms and conditions of services to be provided by Carl Sayles, PsyD, LMFT for the minor child \_\_\_\_\_ (herein "Patient") and is intended to provide [name of parent(s)/legal guardian(s)] \_\_\_\_\_ (herein "Representative") with important information regarding the practices, policies and procedures of Carl Sayles, PsyD, LMFT (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 before signing it.

#### ***Policy Regarding Consent for the Treatment of a Minor Child***

Therapist 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 psychotherapy, Therapist will require that Representative submit supporting legal documentation, such as a custody order, prior to the commencement of services.

#### ***Therapist Background and Qualification***

Therapist draws from over 20 years of experience in the mental health and related fields, working with individuals, couples, families and children, looking at issues involving grief and loss, struggles with self-esteem, depression, the pain of separation and divorce, anger, abuse, alcohol and substance dependency, relationship differences, the challenges associated with bipolar, and others. Therapist also works with therapeutic groups and provides consultations, supervision, and training for mental health professionals as well.

Therapist received his BA in Humanities/Philosophy from San Francisco State University, MA, in Counseling Psychology from the University of San Francisco, and a Doctorate in Psychology (PsyD) from California Coast University, all of which are accredited institutions.

Therapist has an extensive background and understanding of the Satir Transformational Systemic Process Model using it as a guide in working with people from all walks of life. The Satir model is a way of perceiving the world, where beliefs can be explored and changed. Therapist is also associated with the Association for Comprehensive Energy Psychology and brings these tools into the therapeutic process. These models are based on bringing about change in order to live life more confidently, competently, and congruently.

***Further information about Carl Sayles, PsyD, LMFT, his qualifications, education, curriculum Vita and a more extensive explanation of the therapeutic process please visit: [www.healingpalce.info](http://www.healingpalce.info).***

#### ***Risks and Benefits of Therapy***

A Minor patient will benefit most from psychotherapy when his/her parents or guardians or other caregivers are supportive of the therapeutic process. Psychotherapy is a process in which Therapist and Patient discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient can experience his or her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist.

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A Psychotherapeutic – Counseling Practice  
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Progress and success may vary depending upon 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, a reduction in feelings of stress and anxiety or depression, an increased or improved sense of well-being, improved interpersonal relationships, increased comfort in social, work and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part to Patient, including and active participation in the therapeutic process, honesty, openness, and a willingness to explore change and experience change. There is not guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remember and discussing unpleasant events, feeling and experiences. The process may evoke strong feelings of sadness, anger, fear, and the like. There may be times in which Therapist will challenge Patient's perceptions and assumptions, and explore a different perception. The issues presented by you the Patient may result in unintended outcomes, including challenges in personal relationships. Patient should be aware that any decision on the status of her or his personal relationship is the responsibility of Patient.

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 she or he has regarding her or his progress in therapy with Therapist.

The Patient can expect that the Therapist will share his understanding of the problems and challenges discussed during therapy and how they will be treated, what approaches might be used and other possible treatment approaches the Therapist is aware of, the advantages and or disadvantages of each, and to the best of the Therapist's knowledge, what might happen without treatment.

***Professional Consultation***

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

***Records and Record Keeping***

Therapist may take notes during the 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 normal record keeping process at the request of any patient. 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 with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of records under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Therapist will maintain Patient's records for ten years following termination of therapy. 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 or 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 and 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.



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### **Patient Litigation**

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient and another individual, or entity, are parties. Therapist has a policy of not communicating with Patient's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient'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, Patient agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made himself available for such an appearance at Therapist's usual and customary hourly rate of \$250.00. **In addition, therapist will not make any recommendation as to custody or visitation regarding patient.** Therapist will make every effort to remain uninvolved in custody disputes between Patient's parents.

### **Psychotherapist-Patient Privilege**

The information disclosed by Patient, as well as any records created, are 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 received 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 Patient or Patient's representative. Patient should be aware that he or she might be waiving the psychotherapist-patient privilege if he or she makes his or her mental or emotional state an issue in a legal proceeding. Patient should address any concerns he or she might have regarding the psychotherapist-patient privilege with his or her attorney.

### **Fee and Fee Arrangements**

The usual and customary fee for service is \$120.00 per 50-minute session. Sessions longer than 50-minutes are charged for the additional time pro-rata.

The agreed upon fee between Therapist and Patient is \_\_\_\_\_ .

Therapist reserves the right to periodically adjust this fee. Patient will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with other third-party payors, or by agreement with Therapist.

From time-to-time, Therapist may engage in telephone contact with Patient for purposes other than scheduling sessions. Patient 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 Patient's request and with Patient's advance written authorization. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes.

Patients are expected to pay for services at the time services are rendered. Therapist accepts cash, checks – made payable to Carl Sayles, PsyD, and Credit Cards.



### **Insurance**

Patient is responsible for any and all fees not reimbursed by his or her insurance company, managed care organization, or any other third-party payor. Patient is responsible for verifying and understanding the limits of his or her coverage, as well as his or her co-payments and deductibles.

Therapist is a contracted provider with specific managed care organizations and as such has agreed to a specified fee. If Patient intends to use benefits of his or her mental health insurance policy, Patient agrees to inform Therapist in advance. Therapist will discuss specific requirements regarding Patient's responsibilities, co-pays, and authorization process. A treatment summary can also be provided for submission to the third-party of her or his choice to seek reimbursement of fees already paid.

### **Cancellation Policy**

Patient is responsible for payment of the agreed upon fee for any missed session(s). Patient is also responsible for payment of the agreed upon fee for any session(s) for which Patient failed to give Therapist at least 24 hours notice of cancellation. Cancellation notice should be left on Therapist's voice mail at (916) 961-2431.

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**Therapist Availability**

Therapist’s office is equipped with a confidential voice mail system that allows Patient to leave a message at any time. 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. Therapist is unable to provide 24-hour crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, he or she should call 911, or go to the nearest emergency room.

**Termination of Therapy**

Therapist reserves the right to terminate therapy at his 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 has the right to terminate therapy at her or his 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. 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. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient.

**Notice of Privacy Practices**

I have received a copy of the “Notice of Privacy Practices” \_\_\_\_\_ and understand it is also available at [www.healingplace.info](http://www.healingplace.info) (Initial)

**Acknowledgment**

By signing below, Representative and Patient acknowledges that he or she has reviewed and fully understands the terms and conditions of this Agreement. Representative and Patient 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. Patient 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.

A copy of this Agreement shall be considered valid.

**I understand that by signing this document I am financially responsible to Therapist for any and all charges, including unpaid charges by other third-party payors.**

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Signature of Patient (if Patient is 12 or older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Representative (and relationship to Patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Representative (and relationship to Patient)

\_\_\_\_\_  
Date

**Patient \*Confidential Information**

Today's date: \_\_\_\_\_

**A. Personal Information**

Your name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone Contact: \_\_\_\_\_ *May I contact you at this number?*  Yes  No

e-mail: \_\_\_\_\_ *May I contact you through email?*  Yes  No

Calls or e-mail will be discreet, but please indicate any restrictions: \_\_\_\_\_

**B. Your goal in therapy:** *What would you like to accomplish in our work together?*

\_\_\_\_\_

*How might I be of help to you?* \_\_\_\_\_

\_\_\_\_\_

**C. Referral:** *How did you find me?*

\_\_\_\_\_

May I have your permission to thank this person for the referral?  Yes  No

**D. Your medical care:** *From whom or where do you get your medical care?*

Clinic/Medical Doctor's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

If you enter psychotherapeutic treatment with me, may I consult with your medical doctor, as necessary, so that she or he can be fully informed and coordinate your treatment together?  Yes  No

**E. Your current employer:**

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Work phone: \_\_\_\_\_ *May I contact you at work?*  Yes  No

**F. Preferred method of payment:**  Cash  Check  Credit Card  Other: \_\_\_\_\_

**G. Emergency Information:** *If some kind of emergency arises and I cannot contact you directly, or I need to contact someone close to you, who shall I call?*

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Your relationship to this person: \_\_\_\_\_

**\*This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.**