Orange County Family Therapy
Individuals* Couples* Families* Adolescents* Marriage

Dr. Vennus Zand, LMFT #84766
(949) DIAL-MFT (949) 342-5638
8 Corporate Park, Suite 300 Irvine, CA 92602

Consent for Treatment of a Minor

The information contained in this agreement is in addition to the information contained in the Consent for Treatment, a copy of which has been provided. In order for me to provide services to your child, all forms must be read and signed. If there are custody arrangements pertaining to this child, a copy of the custody agreement must be provided before any services can be provided.

The involvement of children and adolescents in therapy can be highly beneficial to their overall development. Very often, it is best to see them with parents and other family members; sometimes, they are best seen alone. I will assess which might be best for your child and make recommendations to you. Obviously, the support of all the child's caregivers is essential.

Because my role is that of the child's helper, I will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist.

Therapy is most effective when a trusting relationship exists between the therapist and client. Privacy is especially important in securing and maintaining that trust. The issue of confidentiality is critical in treating children. When children are seen with adults, what is discussed is known to those present and should be kept confidential except by mutual agreement. Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their parents have this right. However, unless children feel they have some privacy in speaking with a therapist, the benefits of therapy are potentially lost. The content of your child's sessions must be confidential in order to enable your child to confide in his/her therapist, and for therapy to be effective. This is especially true for adolescents. Therefore, it is necessary to work out an arrangement in which children feel that their privacy is being respected, at the same time that parents have access to certain critical information. This Consent for Treatment of Minor agreement must have the understanding and signed approval of the parents or other responsible adults and of the child in therapy and is written verification of this agreed upon arrangement.

If your child is an adolescent, it is likely that he/she will reveal sensitive and personal information, and possibly information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. Unless your child is at serious risk of harming him/herself or another, I will not share with you what your child has disclosed to me without your child's consent.

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The following circumstances override the general policy that children are entitled to privacy while parents or guardians have a legal right to information:

Confidentiality and privilege are limited in cases involving child abuse or danger to self or others. In these cases, I am legally required to make a report to the appropriate agency and will attempt to involve parents as much as possible. If I believe your child is at serious risk of harming him/herself or another, I will inform you immediately.

I ask that you inform me ahead of time that you are considering stopping therapy, and allow me the option of having a closing session(s) to appropriately end the treatment relationship.

Any evaluation, treatment, or reports ordered by, or done for submission to a third party such as a court or a school will be shared with that agency with your specific written permission. Please note that I do not have control over information once it is released to a third party such as your insurance company.

My role is limited to providing treatment, and I will not be involved in any legal dispute between you as parents. You agree you will not involve me in any legal dispute between you, including a dispute concerning custody or custody arrangements.

I adhere to the following policies in treating children of separated or divorced parents who share legal custody:

1. Both parents must consent to treatment, ideally before the first session with the child.

2. Both parents will be asked to provide information, and be involved as needed in their child's treatment, unless there is compelling reason to not (i.e. when contact is limited by a court).

3. I will not communicate with attorneys for either parent or guardian.

4. Any information provided by one parent may be shared with the other parent.

5. I will not provide custody or visitation recommendations to the court, mediator, and/or psychologist conducting a family psychological evaluation. If the child has a court representative (attorney or advocate) or if requested by both parents, or ordered by the court, I may discuss observations about the child with these parties.

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I, (name)_____,_____(relationship to child)

I, (name) _____,_____(relationship to child)
agree that my/our child (name)_____ should have privacy in his/her/their therapy sessions, and I agree to allow this privacy except in extreme situations, which I will discuss with the therapist prior to the commencement of treatment. At the same time, except under unusual circumstances, I understand that I have a legal right to obtain this information. To increase the effectiveness of the therapy, I agree to the following:

I agree to waive my right to access to my child's treatment record. I will do my best to ensure that therapy sessions are attended. I will not inquire about the content of my child's therapy sessions. If my child prefers not to volunteer information about the sessions, I will respect his/her/their right not to disclose details. Unless my child has been abused or is in clear danger to self or others, the therapist will normally tell me only the following:

- whether sessions are attended
- whether or not my child is/children are generally participating
- whether or not progress is generally being made

The normal procedure for discussing issues that are in my child's therapy will be joint sessions including my child, the therapist, and me and perhaps other appropriate adults. If I believe there is significant health or safety issues that I need to know about, I will contact the therapist and attempt to arrange a session with my child present. Similarly, when the therapist determines that there are significant issues that should be discussed with parents, every effort will be made to schedule a session involving the parents and the child. I understand that if information becomes known to the therapist and has a significant bearing on the child's well-being, the therapist will work with the person providing the information to ensure that parents are aware of it. In other words, the therapist will not divulge secrets except as mandated by law, but may encourage the individual who has the information to disclose it for therapy to continue effectively.

APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24-hour notice. If you miss a session without canceling, or cancel with less than 24-hour notice, my policy is to collect a cancelation fee of $75 [unless we both agree that you were unable to attend due to circumstances beyond your control]. If it is possible, I will

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try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES

By entering therapy, we have begun a professional relationship that has financial implications. I want to take this opportunity to discuss the financial aspects of our therapeutic relationship. The following is a guideline for the financial agreement you are consenting to:

- The standard fee for the initial intake is $200.00
- Each subsequent session is $175.00

Or on a case by case basis:

- After a review with you we have agreed on a fee of _____ per session. This fee is subject to change with sufficient notice to you.

If you are using your insurance provider for behavioral health coverage, you are responsible for any sessions, report writing, consultations, phone sessions, or additional fees not covered by your insurance or EAP.

The fees for telephone contact/consultations (in addition to in person session, not in lieu of) are as follows:

- Under 10 minutes: no charge
- 15-30 minutes: $90
- 31- 50 minutes: $175
- After 50 minutes, each additional 10 minutes is $40

Charges for a scheduled phone session in lieu of an in-person session, will charged at the same rate as in person sessions.

Should you require an in-home consultation/session the fees are: $200 + travel fees (travel fees are a minimum of $35) for a 45-50-minute consultation/session.

_____
Signature of Minor Date

_____
Signature of Parent Date

_____
Signature of Therapist Date

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We, (Parents Names) _____ and _____, are legal custodial parents with decision-making responsibility for (Minor's Name) _____, a minor. (If sole legal custodian please attach a copy of Permanent Court Order Provision.)
We authorize Dr. Vennus Zand, LMFT in her capacity as Licensed Marriage and Family Therapist to begin the mental health assessment and treatment of said minor on (Date) _____. Authorization will be in effect until such time as this psychotherapeutic relationship is terminated.

As legal custodial parent, we understand that we have the right to information concerning our minor child in therapy, except where otherwise stated by law.We also understand that this therapist believes in providing a minor child with a private environment in which to disclose himself/herself to facilitate therapy. We therefore give permission to this therapist to use her discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with us. This is my written consent to the mental health assessment and treatment of minor child under the terms stated above.

IF APPROPRIATE, PARENT WITH DECISION-MAKING RESPONSIBILITY FILL OUT AND SIGN THE FOLLOWING:

I also authorize _____ to sign any and all papers necessary for client's treatment and to participate in treatment. I also authorize _____ to transport client to and from scheduled appointments.

Both parents must consent for treatment unless the treatment is court ordered or one parent is sole legal custodian (please attach provision).

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Witness/Provider Date

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(Please Complete a Separate "Consent to Treat Minor" Form for each minor participating in therapy)

CHILD'S NAME:_____ DOB: ___/___/___ Home Phone: _____SS#:_____-____-_____ Age:_____

Primary Address:_____,_____,_____,_____

(City) (State) (Zip)

PARENTS: (Name all parents/step-parents/legal guardians. CUSTODIAL parent(s) must sign form)

Mother: _____Spouse:_____

Address (or "same"):_____,_____,_____,_____

(City) (State) (Zip)

SS#:_____-____-_____ DOB:___/___/___ Age:____ Cell Phone:_____

Occupation:_____ Work Phone:_____

Home Phone:_____

Father: _____Spouse:_____

Address (or "same"):_____,_____,_____,_____

(City) (State) (Zip)

SS#:_____-____-_____ DOB:___/___/___ Age:____ Cell Phone:_____

Occupation:_____ Work Phone:_____

Home Phone:_____

Guardian: _____ Spouse:_____

SS#:_____-____-_____ DOB:___/___/___ Age:____ Cell Phone:_____

Address (or "same"):_____,_____,_____,_____

(City) (State) (Zip)

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Emergency Contact:

Name: _____ Relationship: _____Phone: _____

Name: _____ Relationship: _____Phone: _____

I, (Print Name) _____ attest that I am the custodial parent of above named minor, and I authorize child to participate in psychotherapy with this office. I agree and understand that I am legally responsible for any and all charges incurred in providing this and/or other services by this office. Copies of documentation of legal custody of child, and any other legal issues pertaining to child must be provided on, or before date of first visit. Copies of these documents will be kept in child's record.

_____ _____

Signature of Parent/Guardian Date