

Informed Consent for Adolescent/Child Therapy Services

Welcome to PRO Recovery & Therapy. This document contains important information about our professional services and business policies. Please read it carefully and make note of any questions you might have. When you sign this document, it will represent an agreement between us. (Professional Recovery Organization is now d/b/a: PRO Recovery & Therapy).

Risks and Benefits

Therapy for adolescents/child can have benefits and risks. Since therapy often involves discussing unpleasant aspects of one's life, your child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. Working through difficult emotions can sometimes lead to an increase in difficult behaviors before the adolescent/child is able to utilize new skills or fully integrate their experiences. On the other hand, therapy has been shown to have benefits for individuals who go through it. Therapy can lead to better relationships, solutions to specific problems, significant reductions in feelings of distress and improved self-esteem. But there are no guarantees of how an adolescent/child will respond. Adolescents/children are unique and holistic beings that sometimes require assistance and support in order to grow and develop to their fullest potential. Counseling can often be beneficial for adolescents/children and their families.

Confidentiality

Therapists who work with adolescents/children have the difficult task of protecting the adolescent's/child's right to privacy while at the same time respecting the parent's or guardian's right to information. Therapy is most effective when a trusting relationship exists between the therapist and the adolescent/child. Privacy is especially important in securing and maintaining that trust. In our practice, we provide individual counseling to adolescents/children and ensure the caregiver/parent is involved in the process through consultation with them. At times, the parent/caregiver may even participate in the sessions. However, to ensure a child's privacy we will not provide detailed information to the parent/caregiver regarding what the child shared unless the child provides consent. Instead, general themes, ideas and recommendations will be provided as well as support and encouragement to the parent/caregiver. If it is necessary to refer your child to another mental health professional with more specialized skills, we will share that information with you. Other areas of confidentiality will be discussed during the first session with the child/adolescent in the presence of their parent/caregiver to ensure complete understanding and agreement prior to the initiation of counseling.

Revoking Consent

Both you and your child/adolescent may end the counseling relationship at any time, without penalty or prejudice (with the exception of late cancellations/no shows as identified on the consent for treatment form). While free to discontinue services at any time, it is preferable to have a closing session or phone call, to ensure the adolescent/child understands that counseling is ending and to provide an appropriate closure to the experience. You may also have the right to refuse or discuss modifications of any of my counseling techniques or suggestions that you believe may be harmful.

Fees, Payment and Cancellation

Intake – Diagnostic Assessment	\$200
Individual Psychotherapy 30 min	\$85
Individual Psychotherapy 45 min	\$110
Individual Psychotherapy 60 min	\$160
Crisis Psychotherapy 30 min add on	\$115
Interactive Complexity add on	\$16

The fees listed above represent the fees PRO Recovery and Therapy bills to your insurance company. The amount you are responsible for is the “allowed amount” on your explanation of benefits, which may be paid by the insurance company, owed by you, or a combination thereof. Total charges will not be known until your care is complete and your claims have been billed to and processed by the insurance company if you are using insurance to pay for your services.

I understand I am responsible for all charges not covered by my insurance company.

*Sliding fee scale available upon request

I understand I can be up to 20 minutes late for my scheduled session. If I am running late, I will call my provider to let them know. If I need to cancel or reschedule an appointment, I will give my provider twenty-four (24) hours' notice. I understand failure to attend a session without giving notice will result in a \$50 no show/late cancellation fee and that this fee cannot be billed to my insurance, meaning I will be responsible to pay the fee in full. I understand that exceptions for unforeseen or unavoidable situations are at the discretion of the provider.

Acknowledgment and Consent

By your signature below, you are indicating that you read and understood this consent form or that any questions you had about this consent form were answered to your satisfaction.

Consent for Treatment of Minors: I/we consent that my adolescent/child under the age of 18, _____ (name of child) may be treated as a client by PRO Recovery & Therapy. This form is in effect until _____ (date) or until 12 months after the consent was given. Consent can be revoked at any time.

I affirm that I am the legal guardian of (name of child/adolescent): _____

Date of Birth (child/adolescent): _____.

Parent or Guardian’s name (please print) _____

Parent or Guardian’s Signature _____

Date: _____