

# **LISTENING EAR COUNSELLING & CONSULTANCY PTE LTD**

## **Informed Consent to Treatment and Recipient's Rights (Minor)**

### **PSYCHOTHERAPY INFORMATION DISCLOSURE STATEMENT**

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This framework helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you and your child have certain rights that are important for you to know about because this is your therapy, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

#### **I) Your Rights/My Responsibilities to You as Your Therapist**

**A. Confidentiality:-** In order to ensure that a child is receiving the best possible treatment, the parents, child and therapist must work together. In order to accomplish this, the child needs to begin to trust the counselor, and have the confidence that anything discussed during a session will not be revealed to their parents unless it is abuse and is required by law. Hence I will not be able to divulge information without the child's consent. If a situation escalates into something potentially harmful or life threatening, the counselor therapist will notify parents and other authorities as required by law. Hence with the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. The centre will not share information with any person besides the therapist and his supervisor unless: a) You consent in writing, b) The disclosure is allowed by a court order, or c) The disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation. d) The Centre learns that the child plans to physically harm or endanger another person. e) Where we suspect that a child, or other person, has been physically abused, neglected, and/or sexually abused. It is the Centre's duty to warn any potential victim, when a significant threat of harm has been made and the centre reserves this right to inform the authorities. Client data of clinical outcomes may be used for program evaluation purposes or research purposes, but individual identity will not be disclosed to outside sources. The therapist may at times speak with professional colleagues about the case to ensure best service without asking permission, but your identity will be disguised.

**B. Record-keeping :-** I take notes during session to keep track of your process, certain themes and patterns to explore etc. These are kept in individual files and are confidential and can only be accessed by me or my supervisor if necessary.

**C. Availability:** I am available for regularly scheduled appointment times, unless I am in training or on vacation.

You can call me to make an appointment, and depending on the issue I will find time for you. I do not replace emergency services or doctors, but you can also call me if you need to talk to me urgently, I do not charge for phone conversations.

**D. Independent Practice:** While I have supervisors who guide me. I am not partners with, nor do I have any legal association with any other mental health professional.

**E. Other Rights:-** You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

#### **II) Your Responsibilities as a Therapy Client/My Policies**

**A. Timing:** - You are responsible for coming to your session on time and at the time we have scheduled. Generally, one session lasts between **50-60** minutes but it can end earlier by mutual consent. If you are late, we will end on time and not run over into the next person's session. If you miss a session without informing, or request to cancel with less than twenty-four hours' notice, it will be treated as a 'no-show' and you will forfeit your full fees for the session.

**B. Conduct:** - It is expected that you do not come intoxicated with alcohol or other drugs or carry them with you onto the premises. I do not substitute for emergency services, and in case of any emergency, please call the relevant services like 999, IMH, SOS etc. I only see clients by appointments, and so I would greatly appreciate if you could respect my time and other client's privacy by coming on time and not loitering or chatting with other clients in the waiting area.

**C. Fees:** - You are responsible for paying for your session before each session. My fee for an individual session of less than hour is 250 SGD in person, or 200 SGD if on Zoom. If we decide to meet for a longer session, I will bill you accordingly.

**D. Complaints:** - If you are unhappy with what is happening in therapy, I hope you will talk about it with me so that I can respond to your concerns. I take all criticism seriously, and with care and respect. If you give it in writing, I will attach it to your file. You are also free to discuss your complaints about me with anyone you wish, and do not have any responsibility to maintain confidentiality, since you are the person who has the right to decide what you want kept confidential.

**E. Termination or Treatment/Non-Voluntary Discharge from Treatment:**

The therapist may terminate treatment and notify the concerned authorities if:-

- i. You exhibit physical violence/self-harm, verbal abuse/threats, carry weapons, or engage in illegal acts at the clinic OR
- ii. You refuse to comply with stipulated programme rules, or refuse to comply with treatment recommendations, OR
- iii. You do not make payment or payment arrangements in a timely manner. OR
- iv. If some problem emerges that is not within the scope of competence of the therapist.

**CONSENT TO TREATMENT**

I, Mr/Mrs/Miss \_\_\_\_\_, the undersigned, of adult age (21 years and above)  
 ICNO: \_\_\_\_\_ residing at \_\_\_\_\_ Postal Code \_\_\_\_\_  
 contactable at (HP No) \_\_\_\_\_ hereby attest that \_\_\_\_\_ (name of child)  
 Master/Miss \_\_\_\_\_ ICNO: \_\_\_\_\_ who is my \_\_\_\_\_ (state  
 relationship with child eg son/daughter/ward/student) residing at \_\_\_\_\_ Postal Code \_\_\_\_\_  
 has **voluntarily** entered into treatment, at **LISTENING EAR COUNSELLING & CONSULTANCY PTE LTD (SINGAPORE)** hereby referred as the **Centre** run by **DESOUZA KARL FRANCIS**, hereby referred as the **Therapist**.

We have read this informed consent completely and, had sufficient time to be sure that I/We considered it carefully, and asked any questions that I/We needed to. I/We have received full and satisfactory response and agree to the provisions freely and without reservations. The rights, risks and benefits associated with the treatment have been explained to me. I/We understand that the therapy may be discontinued at any time by either party. I understand my/our rights and responsibilities as a client, including the right to confidentiality and privacy and my therapist's responsibilities to me. I/We understand that the Therapist does not give any advice nor offer any solutions but I/my child is/are responsible for my own/their behavior and the choices I/they make and I/We will not hold the Therapist responsible for any action on my/our part. I/We agree to undertake therapy with the Therapist/Centre. I know I/We can end therapy at any time I/We wish and that I/We can refuse any requests or suggestions made by the Therapist. I/We understand the limits to confidentiality required by law. I/We understand that my therapist from time to time makes teaching and research contributions using disguised client material. By consenting to treatment, I/We give consent to this process of professional contribution and the right to use disguised material without financial remuneration. I/We agree to pay the fees agreed upon at the end of every session.

**With my signature below, I/We acknowledge that I/We have read, understand, and agree to all of the above.**

My/Our signature below indicates that I/We have been explained our rights and responsibilities and understand all this and take full responsibility for my/our child/ward/. I/We also agree that the role of the Centre/Therapist is limited to providing treatment and the Centre/Therapist will not be involved in any legal dispute especially one involving custody or custody arrangements in case of divorce etc.

I also permit a copy of this authorization to be used in place of the original if needed.

I freely consent to treatment and agree to abide by the above stated policies and agreements with the CENTRE, namely **LISTENING EAR CLINIC & CONSULTANCY PTE LTD (SINGAPORE)**

\_\_\_\_\_  
 Minors Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Parent/ Guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of THERAPIST

\_\_\_\_\_  
 Date