SANDBAR

PSYCHOLOGICAL SERVICES

INFORMED CONSENT FOR TREATMENT

Client Information

Client Name: _____

Date of Birth: _____ Age: _____

Parent/Guardian Name(s) if minor: _____

1. Consent for Psychological Treatment

I/we voluntarily consent to mental health treatment for the above-named party by the therapist/practice listed above.

Services may include:

- diagnostic assessment,
- individual therapy,
- family therapy,
- parent consultation,
- and treatment planning.

I/we understand that therapy involves discussion of emotional, behavioral, relational, academic, and family concerns.

2. Risks and Benefits of Therapy

Potential Benefits May Include

- Improved coping skills
- Emotional support
- Behavioral improvement
- Increased self-awareness
- Improved relationships

Potential Risks May Include

- Uncomfortable emotions
- Discussion of difficult experiences
- Temporary emotional distress
- Changes in family/interpersonal relationships

No guarantees regarding treatment outcomes have been made.

3. Confidentiality and New Jersey Law

Information disclosed in therapy is generally confidential under applicable federal and New Jersey law.

However, confidentiality may be limited in circumstances including but not limited to:

- suspected child abuse or neglect,
- danger to self,
- danger to others,
- court order,
- medical emergency,
- or other situations required by law.

In New Jersey, parents/legal guardians generally have rights related to treatment information for minors. At the same time, maintaining an appropriate level of privacy for adolescents is often clinically important to effective treatment.

The therapist may use professional judgment in determining what information will be shared with parents/guardians while protecting the therapeutic relationship and the welfare of the minor.

4. Custody and Legal Authority

The signing parent/guardian represents that they have legal authority to consent to treatment.

☐ Married parents with joint legal custody

☐ Divorced/separated parents with joint legal custody

☐ Sole legal custody

☐ DYFS/DCPP involvement

☐ Other: _____

If custody agreements, restraining orders, or court orders affect treatment decisions or parental access to records, copies must be provided before treatment begins.

The therapist may request consent from both legal guardians when clinically or legally appropriate.

5. Parent/Guardian Participation

Parent/guardian involvement may be necessary and beneficial to treatment. This may include:

- periodic parent sessions,
- behavioral planning,
- safety planning,
- treatment updates,
- and coordination regarding school or medical issues.

The therapist will discuss recommendations for parent participation as treatment progresses.

6. Communication and Electronic Contact

The practice may communicate by: phone, voicemail, email, text messaging, or client portal.

Electronic communications may involve some privacy risks despite reasonable safeguards.

The practice should not be contacted through electronic means for emergencies or urgent crises.

7. Telehealth Services (If Applicable)

Telehealth sessions may occur using HIPAA-compliant video technology.

By consenting to telehealth services, I/we understand:

- technology failures may occur,
- privacy cannot be guaranteed absolutely,
- emergency location information may be required,
- and telehealth may not be appropriate for all situations.

8. Fees and Financial Policies

Session Fee for Intake: $250

Session Fee for Follow-Up Session: $200

Missed Session Policy:

I request 24 hours-notice of cancellation of your appointment. Except in cases of unavoidable emergency the session fee is payable in full if you do not show or cancel with less than 24 hours-notice. Insurance Policy:

Insurance Policy:

I am an out-of-network provider, but you may still submit for out-of-network benefits. I will provide you with a detailed receipt (Superbill) which you can use to get reimbursement from your insurance company; please be sure to call your insurance company to verify your specific out-of-network reimbursement benefit.

9. Emergencies

This practice does not provide 24-hour emergency services.

In emergencies, contact:

- 911
- local emergency room
- 988 Suicide & Crisis Lifeline
- or appropriate emergency services

10. Release of Information

Communication with schools, physicians, attorneys, or other providers generally requires a signed Release of Information authorization unless otherwise permitted or required by law.

11. Consent and Signatures

I/we acknowledge that:

- I/we have read this form,
- had the opportunity to ask questions,
- understand the information provided,
- and voluntarily consent to treatment for the minor

Client Signature:

Printed Name: _____

Signature: _____

Date: _____

Parent/Guardian Signature (if applicable):

Printed Name: _____

Signature: _____

Relationship to Minor: _____

Date: _____

Second Parent/Guardian Signature (if applicable):

Printed Name: _____

Signature: _____

Relationship to Minor: _____

Date: _____

Therapist:

Printed Name/Credentials: _____

Signature: _____

Date: _____