Serendipity Therapy Services
855 Central Dr. #8
Odessa, TX, 79761
(432) 530-6452

INFORMED CONSENT FOR TREATMENT AND PARENT/GUARDIAN PARTICIPATION

You have taken a positive step in deciding to seek therapy for your child. It is the belief of Serendipity Therapy Services that therapy works best in a collaborative environment and that children heal and grow best with supportive adult involvement. This document outlines your child's rights as well as various legal requirements related to therapy services. Please read through it carefully. If you have questions related to this document or any treatments provided to your child, please discuss it with your child's therapist.

PARENT AUTHORIZATION FOR MINOR'S MENTAL HEALTH TREATMENT

By signing this form, you are indicating that you give consent for your child to receive services at Serendipity Therapy Services. You further acknowledge that you have the legal right consent to mental health treatment for your child.

Per Texas law, a therapist treating a child who is the subject of a court order must have a copy of that court order on file and must receive consent from all legal guardians of the child. If you share legal custody of this child with another individual, please inform your child's therapist immediately. We will ask you to provide us with a copy of the most recent custody decree that establishes custody rights of you and the other parent, or otherwise demonstrates that you have the right to authorize treatment for your child. If required by law, we will also ask for contact information for the other adult(s) so we can obtain consent for treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, we will strive to listen carefully so that we can understand your perspectives and work together in helping your child meet their treatment goals.

CONFIDENTIALITY

HIPAA protects the relationship between a client and therapist, and information cannot be disclosed without the client's permission. Details related to your child's counseling sessions will be kept confidential and will not be disclosed to anyone, including you, except in specific circumstances outlined in this document. Your child's therapist may discuss your child's counseling sessions vaguely to help protect their right to confidentiality in their therapy sessions.

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Exceptions to confidentiality include;

1. If the child agrees to information being shared. In many circumstances, the therapist will encourage the child to share this information themselves while the therapist acts as a support person or mediator in the conversation.
2. Suspected abuse and/or neglect of a child, dependent adult, or elderly person currently or in the past. It is required by law that this is reported to the appropriate authorities immediately.
3. If a client is threatening serious bodily harm to another person/s, therapists must notify the police and inform the intended victim.
4. If a client expresses intent to harm himself or herself, the therapist will make every effort to engage the cooperation of the child and their parent to ensure their safety. If the child and/or parents do not cooperate with efforts to develop a safety plan, we will take further measures without their permission that are provided to us by law to ensure their safety.

INDIVIDUAL PARENT/GUARDIAN COMMUNICATIONS WITH PROVIDERS

In the course of our treatment of your child, we may meet with the child's parents/guardians either separately or together. Please be aware that our client is your child – not the parents/guardians, nor any siblings, or other family members of the child. If we meet with you or other family members during your child's treatment, we will document that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

DISCLOSURE OF MINOR'S TREATMENT INFORMATION TO PARENTS

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. It is our policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then your therapist will need to use their professional judgment to decide whether your child is in serious and immediate danger of harm. If the therapist feels that your child is in such danger, they will communicate this information to you. Even though we have agreed to keep your child's treatment information confidential from you, we may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, we will encourage your child to tell you, and we will help your child find the best way to do so.

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PARENT/GUARDIAN AGREEMENT NOT TO USE MINOR'S THERAPY INFORMATION/RECORDS IN CUSTODY LITIGATION

We understand that court cases, whether civil or criminal, can be stressful for all involved, especially your child. However, it is the policy of Serendipity Therapy Services that therapists are experts in providing therapeutic care, not testifying in court. Additionally, a therapist becoming involved in court related matters may complicate or destroy the therapeutic relationship and trust built between therapist and child.

Should one of our therapists receive a subpoena for a court case involving your child, the card on file will be charged a non-refundable $2000.00 retainer fee. This retainer will be charged for services related to the court case. These services include preparation of records, testifying in court, preparing an affidavit, travel time, and any other services required. These services will be billed against the retainer at your therapist's hourly rate. If the retainer is depleted, the card on file will be charged for each hour of services performed beyond the retainer on a weekly basis. Services related to court can't be billed to insurance.

Your therapist is unable to provide an opinion on custody, parental fitness, or visitation recommendations.

By signing below, you acknowledge that you have read and agree to the information outlined in this document. You further acknowledge that you have discussed all questions and concerns with your child's therapist and, if more concerns or questions arise, you will address those with the therapist assigned to your child.

_____ _____

Childs Full Name Date of Birth

_____

Parent/Guardian Printed Name

_____ _____

Signature of Parent/Guardian Date

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Fee and Payment Agreement/Cancellation Policy

Sessions are approximately 45-50 minutes in length. Every attempt is made to see clients on time. To work towards this goal, payment is due when services are rendered. All sessions will end no later than 10 minutes to the hour. Payments can be made by debit or credit card through our payment portal.

Twenty-four (24) hours' notice is required to cancel or reschedule an appointment to avoid being billed for a cancellation fee.

If you are more than 10 minutes to your appointment without notifying your therapist, the card on file will be charged the cancellation fee of $50 and your appointment will be cancelled. You will need to call our office to schedule your next appointment. If you have recurring appointments, please note that after 3 late cancellations/no shows your future appointments will be cancelled as well.

Payment is due at the time of service. The private pay rate for therapy sessions is $120 per 45–50-minute session or $80 per 30 minute session. Should your therapist be required to participate in legal proceedings you will be charged a $2000 non refundable retainer to cover initial costs of court preparation and $120 per hour worked once the retainer is dissolved.

We do have therapists who are in network with various insurance companies. If your therapist accepts your insurance, you will be responsible for the payment of your copay at the time of services being rendered. Please refer to the agreements through Headway for more information about copays and benefits. Insurance does not cover cancellation fees; the use of insurance does not absolve the late cancellation fee.

_____ _____

Childs Full Name Date of Birth

_____

Parent/Guardian Printed Name

_____ _____

Signature of Parent/Guardian Date

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PAYMENT AUTHORIZATION/CREDIT CARD AUTHORIZATION

Please complete all fields below. You may cancel this authorization at any time by contacting our office by email.

Credit Card Information				
Card Type:	☐ Mastercard	☐ Visa	☐ Discover	☐ AMEX
Card Number:				
Expiration:				
Billing Zip:				

I, _____, authorize Serendipity Therapy Services, to charge my credit card above for agreed upon purchases or therapeutic sessions via Face-to-Face or Telehealth. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Signature of Card Holder Date

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Authorization to Release Mental and Medical Health Records

Client Name:	
Address:	
City:	State:
Zip:	Phone #:

I, _____, parent or guardian of _____, authorize the disclosure of information related to my child's mental or physical health from and to the named providers below. I understand that I may be required to sign additional disclosure paperwork with my child's other providers to ensure appropriate continuity of care.

Organizations/Entities Authorized to Disclose Private Health Information	
Serendipity Therapy Services	Name of Entity or Individual:
855 Central Dr. #8	Address:
Odessa, TX, 79761	City/State/Zip:
(432) 530-6452	Phone:

The protected health information to be disclosed includes the following: (check all that apply)

___ Assessment Information
___ Diagnosis
___ Treatment Planning Notes
___ Progress & Treatment Notes
___ Communicable Disease Information
___ Medication
___ Psychiatric Evaluation
___ Results of Psychological Testing
___ Recommendations
___ Reasons for Termination
___ Appointment Information
___Other: Please explain
_____

For the purpose of continuity of care, education, legal, insurance, billing, and collaboration.

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I understand that this release is valid for one year or until I withdraw my consent in writing, whichever occurs first. Withdrawal of consent for the release of mental health and medical records does not destroy or remove records or information already obtained.

I acknowledge that this authorization is voluntary and that payment or eligibility for benefits for my health care will not be affected if I do not sign this form. I also understand that the information disclosed because of this authorization may no longer be protected by privacy laws and may be disclosed by the company or individual receiving the information.

_____

Parent/Guardian Printed Name

_____ _____

Signature of Parent/Guardian Date

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CHILD THERAPY INTAKE FORM

Information About Person Completing This Form

Full Name: _____

Phone #: _____ Email: _____

Information About Other Parent/Legal Guardian

Full Name: _____

Phone #:_____ Email: _____

Information About Your Child/The Client

First Name: _____ Last Name: _____

D.O.B.: _____ Ethnicity: _____

Religion: _____ Sex/Gender: _____

Home Address: _____

Who does your child live with? _____

Academic Information

School Attended: _____ Current Grade Level: _____

Typical Grades: _____

In 2-3 sentences, briefly describe the reason you are seeking therapy for your child.

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How intense is your child's emotional distress? (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe) Circle One Please describe:
How has this distress affected your child's ability to participate in and perform at school, with peers, extracurricular activities, or with family?
When did these problems start? Was there anything new occurring in child's life at this time?

Psychiatric/Medical History
Please list any psychiatric or mental health conditions your child has been diagnosed with:

Please list any medical or physical health conditions your child has been diagnosed with:

Please list any medications your child is currently taking. Include any over the counter medications and vitamins.

Name of Primary Care Provider: Phone #:

Name of Psychiatrist: Phone #:

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Mental Health Treatment History

Has your child ever been hospitalized for psychological or psychiatric reasons? If yes, please describe where, when, and what occurred.

Please tell us about any other mental health professionals your child has consulted with in the past. Include approximate dates, type of profession seen, reason for consultation, nature of treatment, and outcome of treatment.

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Current Habits
Please describe your child's current habits in each of these areas:

Smoking/Vaping	Drinking
Illegal Drug Use	Electronic Use (TV, Phone, Video Games, etc.)
Caffeine Intake	Exercise
Eating	Fun and Relaxation
Sleeping	Chores and Responsibility

Relationships
Please describe your child's current relationship with each of the following people, if applicable:

Biological Mother

Biological Father

Step-Parents

Legal Guardians (if not parents)

Siblings

Extended Family

Friends

Girlfriend/Boyfriends

Classmates

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Stressful Life Events

Please describe any significant or stressful life events that your child has been experiencing:

	No	Yes	If yes, please describe
Recent move or change in school?			
Bullied or ignored by peers?			
Academic difficulties?			
Weight control issues?			
Sexual orientation concerns?			
Self-injury?			
Death or Illness of a loved one or pet?			
Family conflict?			
Separation or Divorce?			
Other?			

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What are your child's positive qualities and skills? What do you like about your child? What qualities have helped your child to succeed at overcoming difficulties in the past?

What are your child's interests (sports, hobbies, talents, etc.)

Does your child agree that the problem that she or he is seeking help for is problematic?

What are some goals you would like addressed in therapy with your child? What would you like them to achieve by attending therapy?

What concerns do you have about your child attending therapy or working on these problems?

Is there anything not already included that you would like your child's therapist to know?