Informed Consent for Treatment of Minors

I, ____, hereby attest that I have voluntarily entered.
Printed Name of Minor Client

into treatment at Core Balance Counseling (CBC). Further, I consent to have treatment provided by a provider who is either a counselor, social worker, or intern and is under the supervision of Julia Spain, LPC or Stacy Bliss, LPC. Julia and Stacy can be reached at 480.912.4691.

Treatment of Children and Adolescents

Counseling can be highly beneficial to your overall development. It can help you learn more about yourself and others and learn how to use coping skills to manage stress, emotions, and relationships. As part of the initial assessment, it may be helpful for your provider to meet with you and your parent(s)/guardian(s) together to understand various perspectives and dynamics. After the assessment, your provider will make recommendations and you, along with your provider, will identify goals for counseling and they will be communicated with your parent(s)/guardian(s). The support of your parent(s)/guardian(s) is important for your success.

What To Expect

We are here to support you on your journey toward increasing self-awareness, healing, learning coping skills, personal growth, and transformation. In our sessions, you can expect a safe, non-judgmental space where you are free to express yourself openly. Together, we will explore your thoughts, feelings, and experiences, working collaboratively to understand challenges and discover effective ways of coping. Our goal is to empower you with the tools to navigate life's challenges and build resilience. Your well-being is our priority, and we are committed to helping you achieve your goals. If you ever have questions or concerns, know that we are here to listen and support you every step of the way.

Confidentiality

As a general rule, your provider will keep the information you share within sessions confidential, unless your provider has your permission to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information in a therapy session. In some situations, your provider is required by law, or by the guidelines of their profession, to disclose information whether or not your provider has your permission. These situations are:

- You share a plan to cause serious harm or death to yourself, and your provider believes that you have the intent and ability to carry out this threat in the very near future. Your provider

must take steps to inform a parent or guardian of what you have shared, and how serious your provider believes this threat to be. Your provider must make sure that you are protected from harming yourself.

- You share a plan to cause serious harm or death to someone else who can be identified, and your provider believes you have the intent and ability to carry out the threat in the very near future. In this situation, your provider must inform your parent or guardian, and your provider must inform the person who you intend to harm.
- You are doing things that could cause serious harm to you or someone else, even if you do not intend to harm yourself or another person. In this situation, your provider will need to use their professional judgment to decide whether a parent or guardian should be informed.
- You tell your provider that you are, or have been, physically, sexually, or emotionally abused, or exploited, or your provider has a reasonable suspicion that you are or have been abused or exploited. Your provider is required by Arizona State law to report the abuse to the department of child services.
- You are involved in a court case and a request is made for information about your counseling. If this happens, your provider will not disclose information without your written agreement unless the court requires the information. Your provider will do what is possible, within the law, to protect your confidentiality. If your provider requires disclosure of information to the court, your provider will inform you that this is happening.

Communicating with your Parent(s) or Guardian(s):
The issue of confidentiality is crucial in treating minors. When minors are seen with adults, what is discussed is known to those present. Minors 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 may be lost. Therefore, it is necessary to work out an arrangement in which children feel that their privacy is generally being respected, at the same time that parents have access to critical information.

Your provider will not openly share with your parent(s)/guardian(s) specific things from the private therapy sessions. This includes activities and behavior that you, your parent(s)/guardian(s) would not approve of, or would be upset by, but that do not put you or someone else at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then your provider will need to use their professional judgment to decide whether you, or someone else, is in serious and immediate danger of being harmed. If your provider feels you are in such danger, this will be shared with your parent or guardian. Your provider will prefer to have the discussion with you about your

need for your parent(s)/guardian(s) to know and allow you to inform your parent(s)/guardian(s) in a family session, without delay.

Notice of Confidentiality and Professional Record Keeping

The confidentiality of the client information and records is protected under federal regulations and state law, according to the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protection and patient rights about the use and disclosure of your protected health information (PHI) for the purposes of treatment, payment, and healthcare operations. As a minor, Arizona State law provides your parent(s)/guardian(s) with the right to request your written records. Please refer to your Notice of Privacy Practices, for additional information.

Communicating with Other Professionals

School: Your provider will not share any information with your school, unless there is permission from you and permission from your parent/guardian. There must be a therapeutic reason for your provider to work directly with your school, and your provider will always serve the role of application and such situation, and professional judgment will always be used by your provider.

Doctor: Sometimes your doctor and your provider may need to work together. For example, if you need to take medication in addition to seeing a counselor, your provider will get permission from you and permission from your parent(s)/guardian(s). The only time your provider will share information with your doctor, even if there is no permission from you, is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

Consent for Behavioral Telehealth

I understand that my health care provider and I have decided to engage in sessions virtually.
I understand that I am legally required to physically be in the state of Arizona at the time of service for all virtual appointments.
My health care provider explained to me how the video conference technology will be used for sessions and that it will not be the same as a direct client/health care provider visit since I will not be in the same room as my provider.
I understand that telehealth has potential benefits including easier access to care and the convenience of private meetings from a location of my choosing.
I understand there are potential risks to this technology, including internet connection issues and interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult/session if it is felt that the videoconferencing connections are not adequate for the situation.
I have had a direct conversation with my provider, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand.

Appointments, Billing, and Cancellation Policy:
Appointments will ordinarily be 53 minutes in duration and scheduled according to your treatment needs. Sessions with an intern will be 45 minutes. **If you need to cancel or reschedule a session, CBC requires that you provide 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, our policy is to collect the amount of your provider's full private pay rate. It is important to note that insurance companies do not provide reimbursement for canceled sessions; thus, you will be responsible for the portion of the fee as described above. In addition, you are responsible for coming to your session on time; if you are more than 10 minutes late, it is your provider's discretion to offer a shorter appointment, however, it will still end on time and your insurance will not be billed and you will be charged your provider's full private pay rate.**

Use of Technology:Telehealth is a service we offer, and we do use HIPAA compliant platforms. Any communication with your provider outside of sessions must be limited to scheduling purposes. We encourage you to communicate with your provider only through your secure patient portal. It is at your provider's discretion to offer communication via text, however, that is only to be used to communicate if you are running late or need to reschedule.

Contacting Your Provider: Your Provider may not be immediately available by telephone and is unable to provide crisis counseling. If you are experiencing an emergency or feel that you were unable to keep yourself safe, call, text, or visit Mind 24/7 at 1.844.MIND24, go to the nearest Emergency Room, or call 911. You may also call or text the mental health emergency number at 988.
We will make every attempt to inform you in advance of planned absences and provide you with the name and phone number of the mental health professional covering my cases. In the event your assigned provider is no longer able to continue services, you will be reassigned to another provider. It will be your choice if you would like to continue treatment services or be transferred to another provider. Your case may be staffed in a group supervision setting for clinical feedback on the best practice approach, but your name will not be released.

Minor Therapy Client: By signing below, you indicate that you understand the information above and the limit to confidentiality. If you have any questions as your therapy progresses, you can ask your provider at any time.

Print Name (Minor)	Signature	Date

Guardianship Status

- **Single Parent**. There is no contact with the other parent. (supplemental form required).
- **Parents are living together (Cohabitating) and unmarried**. Parents must sign "consent for treatment of minor"; if the other parent is unavailable, then the supplemental form is required.
- **Parents are Married.** Both parents must consent to treatment, and both parents must sign "consent for treatment of minors". If the other parent is unavailable, then the supplemental form is required. Both parents must consent to treatment, and both parents must sign consent for treatment of minors. If the other parent is unavailable, then the supplemental form is required.
- **Parents are Divorced.** Parent seeking services for minor has the following custody:
    - **Sole. Parent with Sole Custody,** a copy of a valid court order, signed by the judge must be provided for the minors clinical record. The parent, with sole custody must sign "consent for treatment of minor"
    - **Joint. Parents who share Joint Custody,** a copy of a valid court order, signed by the judge must be provided for the minor's clinical record. Both parents must sign "consent of treatment for minors". If the other parent is unavailable, then the supplemental forms are required.
      The appointment for treatment services cannot be honored, unless the required consent is obtained for Minors.
- **Legal Guardian**. Minor is under the care of a Legal Guardian: documentation must be provided.
- Minor is a ward of Court (DES Legal Guardian).

Parent(s)/Guardian(s):

- I/ We agreed to refrain from requesting detailed information about individual or group therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in family sessions as needed.
- I/We understand that we have the right to request our child records, because my child is a minor. I will agree to respect the confidentialities of my child and their treatment, and will not request for such records.
- I/We understand that I will be informed about situations that could endanger my child, or someone else. I know this decision to breach confidentiality in the circumstances is at the professional judgment of the provider and/or their clinical supervisor.
- I/We agree to communicate our expectations to both our child and their provider of unsafe activities my child may be engaged in at the beginning of therapy, so my child understands the extent of their confidentiality.

______________________________________ ____

Print Name (Parent/Guardian) Signature Date

____

Print Name (Parent/Guardian) Signature Date

____

Provider Signature Date

HIPAA

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please review it *CAREFULLY.*

The privacy of your health information is important to me.

MY LEGAL DUTY

I am required by applicable federal and state law, as well as the ethics of the counseling profession, to maintain the privacy of your health information. I am also required to give you this Notice about my practices, my legal duties, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2006 and will remain in effect until I replace it.

I reserve the right to change my privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changes in my privacy practices and the new terms of my Notice effective for all health information that I maintain, including health information that I created or received before I made the changes. Before I make significant changes in my privacy practices, I will change this Notice and make the new Notice available upon request.

You may request a copy of my Notice at any time. For more information about my privacy practices, or for
additional copies of this Notice, please contact me using the information listed at the top of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

I use and disclose health information about you for ***treatment, payment,*** and ***healthcare operations***. For example:

> ***TREATMENT:*** I may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
>
> ***PAYMENT:*** I may use and disclose your health information to obtain payment for services I provide to you.

HEALTHCARE OPERATIONS: I may use and disclose your health information in connection with my healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

YOUR AUTHORIZATION: In addition to my use of your health information for *treatment, payment,* or *healthcare operations,* you may give me written authorization to use your health information or to disclose it to anyone for any purpose. If you give me an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give me a written authorization, I cannot use or disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY AND FRIENDS: I may disclose your health information to you, as described in the *Patient Rights* section of this NOTICE. I may disclose your health information to a family member, friend, or other person to the extent necessary to help with healthcare or with payment for your healthcare, but only if you agree that I may do so.

PERSONS INVOLVED IN CARE: I may use or disclose health information to notify or assist in the notification of (including identifying or location) a family member, your personal representative, or another person responsible for your care, of your location, your general conditions, or death. If you are present, then prior to use or disclosure of your health information, I will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, I will disclose health information based on a determination using my professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. I will also use my professional judgment and my experience with common practice to make reasonable inferences of your best interests in allowing a person to pick up filled prescriptions, medical supplies, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: I will not use your health information for marketing communications.

REQUIRED BY LAW: I may use or disclose your health information when I am required to do so by law.

ABUSE OR NEGLECT: I may disclose your health information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. I may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY: I may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. I may disclose to authorized federal officials' health information required by lawful intelligence, counterintelligence, and other national security activities. I may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: I may use or disclose your health information to provide you with appointment reminders (such as phone or voice messages).

PATIENT RIGHTS:

ACCESS: You have the right to look at or obtain copies of your health information, with limited exceptions. You may request that I provide copies in a format other than photocopies. I will use the format you request unless I cannot practically do so. I will charge you a fee for expenses such as copy costs and copy/preparation time. You may also request access by sending me a letter to the address at the end of this Notice. If you request copies, I will charge you for my time (at my regular hourly rate of $150), copy costs, and postage if you want the copies mailed to you. If you request an alternate format or a summary/explanation of your health information, I will charge my regular hourly fee for providing your health information in that format.

[Note: In the event that your records are co-mingled (i.e., if you are a part of a Child Custody Evaluation, Family Court Case, family therapy, mediation, or marriage counseling), I need a signed consent by all parties involved in order to release records. Third party records in your file (i.e. doctors, other professionals, and references) have the right to confidentiality, and will not be released by this office unless ordered to do so by law. Please contact those professionals directly for records.]

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which I or my business associates disclosed your health information for purposes, other *than treatment, payment, healthcare operations* and certain other activities, for the last six years, but not before

January 1, 2006. If you request this accounting more than once in a 12-month period, I may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTIONS: You have the right to request that I place additional restrictions on my use or disclosure of your health information. I am not required to agree to these additional restrictions, but if I do, I will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that I communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide a satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that I amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) I may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about my privacy practices or have questions or concerns, please contact me.

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have me communicate with you by alternative means or at alternative locations, you may complain to me using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request.

I support your right to the privacy of your healthcare information. I will not retaliate in any way if you choose to file a complaint with me or with the U.S. Department of Health and Human Services