Mariam A. Mott, Ph.D.
Licensed Clinical Psychologist • PSY 16181

office: (949) 858-6688 email: drmott@drmott.com website: www.drmott.com

Child's Name:_____ **Date of Birth**:_____

PARENT COUNSELING AGREEMENT

This document contains important information about my professional services and business policies. Please read this information carefully and make note of any questions you have so we can discuss them.

BENEFITS, RISKS, AND ALTERNATIVES TO TREATMENT

You have been given this document because you are requesting counseling (also known as therapy) for your child. There are several potential benefits from participating in counseling, including (but not limited to): understanding and improving uncomfortable emotions and/or maladaptive behaviors; improving relationships with peers and/or family; identifying and implementing solutions to specific problems; and increasing self-esteem and self-confidence. Some risks do exist, however. For example, since counseling often involves discussing unpleasant circumstances and/or emotions, your child may experience uncomfortable feelings such as sadness, anger, frustration, anxiety, etc.

I will work with you and your child to identify the primary areas of concern, establish goals for counseling, and work with your child to achieve those goals. In order to do so, information may be obtained from you, your child, your child's teachers, and/or other professionals who have worked with your child. This may be done via interviews, observations, and/or questionnaires.

My theoretical orientation is behavioral and cognitive-behavioral, but I will use a variety of methods and techniques to address the identified issues and achieve the established goals. There are no guarantees as to the nature, extent, or rate of improvement in your child's emotional state and/or behavior.

If you have questions about the services being provided at any time, please feel free to ask for clarification. If for any reason you wish to seek services elsewhere, I will help you locate another mental health professional upon your request.

HOURS/AVAILABILITY/CONTACT INFORMATION

I am available to provide counseling during normal business hours Mondays through Fridays. After-school slots typically fill up first, but I will work with you and your child's schedule to find a mutually convenient time. Exceptions to typical scheduling times can be arranged with advanced notice. Counseling will be conducted at my office:

31371 Rancho Viejo Road, Suite 203
San Juan Capistrano, CA 92675
(949) 858-MOTT (6688)

Sessions are typically offered once per week for 60 minutes. **Sessions that extend beyond 75 minutes will be prorated for the additional time in quarter-hour increments**. The number and frequency of sessions may vary depending on the nature and severity of the issues. If it becomes clear that more extensive services are warranted (e.g., longer duration, group therapy, family therapy, etc.) and/or the intervention of a specialist is required, I will provide you with a referral list of mental health professionals within the community.

Should you need to change your scheduled appointment time, please call me AT LEAST 24 HOURS IN ADVANCE. ***I reserve the right to charge you for the full 60-minute session ($150) for appointments that are cancelled with less than 24-hour notice.*** I can be reached through my office cell phone at **(949) 858-MOTT (6688)**. I can also be reached via email at drmott@drmott.com, although the confidentiality of email communications cannot be 100% guaranteed (see below).

The frequency with which I check messages and emails varies depending on my schedule, so ***please do NOT use email, voice mail, or text messages for emergencies.*** In the event of a mental health emergency, if you are unable to reach me and feel like you can't wait for a return call, contact your family doctor or the nearest emergency room and ask for the psychologist/psychiatrist on call.

CONFIDENTIALITY, PRIVACY, AND RECORD KEEPING

It is important for your child to feel like s/he is in a safe and trusting relationship in order to feel comfortable sharing problems, experiences, and emotions. Therefore, I usually provide parents with general information about the child's progress rather than specifics of counseling sessions. There are some exceptions to this policy, however, including that:

- ✓ I may decide to inform you if your child is engaging in dangerous practices (e.g., substance abuse, sexual promiscuity, suicidal thoughts, etc.).
- ✓ With your child's agreement, I may invite you to participate in counseling in some capacity if I believe it is necessary or helpful for your child. Please keep in mind that **your child** is my client (not you), even if you are asked to participate in counseling.

I am required by law and by the standards of my profession to keep treatment records. As a parent, you are entitled to review your child's complete record if you wish. Because of the importance of trust in the counseling relationship, however, **by signing this document you agree to accept general information about your child's progress in lieu of access to the entire record.** If you insist upon seeing your child's records, I recommend that you review them with me so you can discuss any questions you may have. In rare cases, I may determine that reviewing your child's entire record would have negative consequences for you and/or your child. In that case, I will provide the record to an appropriate mental health professional of your choice.

The confidentiality of communications between you, your child, and myself is important and is generally legally protected. Normally, information about your child can be released only with your written permission. Please note, however, that there are important exceptions to this overall legal and ethical requirement. For example, reports are required in suspected cases of abuse of a child, elderly or disabled person, as well as in situations where a person may be a danger to him/herself or another. Also (upon parental request), I may furnish the information necessary to obtain reimbursement when a third party is expected to pay for some part of the costs of services.

In most legal proceedings, the therapist-client privilege protects information about your child's assessment. Please note, however, that certain Court proceedings, actions before the Board of Psychology, or other illegal activity may limit the ability to maintain confidentiality.

Please be aware that **I do not conduct assessments or provide recommendations for Court-related proceedings.** By signing this form, you agree that:

- ✓ You will not attempt to gain advantage in any legal proceedings from my involvement with your child, and you will instruct your attorney not to subpoena me or to refer in any Court filing to anything I have said or done.
- ✓ Neither parent will ask me to testify in Court, either in person or by affidavit. You understand that I am ethically bound NOT to give my opinion about either parent's custody or visitation suitability.
- ✓ In the case of custody disputes, if there is a Court appointed Evaluator, Guardian Ad Litem, or Parenting Coordinator, I will provide information as necessary (if appropriate Releases are signed and a Court Order is provided), but I will NOT make any recommendation about the final decision.

Occasionally, I may find it helpful to seek consultation with other professionals regarding your child. Such consultations are also legally bound by laws of confidentiality, and I will make every effort to protect confidentiality when discussing your child's case.

Regarding Social Media, my general policy is NOT to accept "friend" requests from current or former clients or their parents (e.g., on Facebook or LinkedIn), since doing so has the potential to compromise counseling and treatment boundaries. Likewise, my general policy is NOT to "follow" current or former clients or their parents on social media sites such as Twitter or Pinterest in order to protect client confidentiality.

SECURITY OF ELECTRONIC INFORMATION

I have taken several measures to strengthen the security of electronic confidential information, including: ***maintaining a password-protected laptop with virus protection; using an internet connection with firewall protection; purchasing HIPAA-compliant email; regularly backing up client information from my laptop onto an encrypted hard-drive; maintaining fingerprint security on my cell phone (my office number is a cell phone); maintaining a security certificate on my website; and not allowing anyone besides me to retrieve my confidential voice mail.*** Despite these measures, the confidentiality of email and text communications cannot be 100% guaranteed (e.g., there is a very small possibility that unencrypted messages can be accessed by unauthorized people and/or that email or text messages might be sent erroneously to the wrong person). Please know that:

- ✓ **You are expected to notify me immediately if you do NOT wish to communicate electronically** (i.e., via email, test messages, and/or cell phones calls/messages).
- ✓ If you share confidential or private information with me via unencrypted email or text message, I will assume that you have evaluated the risks and made an informed decision and I will view doing so as your agreement to take the very small risk that such communication may be intercepted**.**
- ✓ **Your signature at the bottom of this form constitutes your consent to communicate via email and/or text.** Please note that emails and texts will be part of the clinical records.

RELEASE OF INFORMATION

Most insurance agreements require you to authorize me to provide information, including clinical impressions and in rare cases, a copy of the entire record. Once the insurance company has this information, I will have no control over what they do with it.

In order to more completely understand and work with your child, it may be important to obtain records from previous treating professional(s). **Please provide me with information on previous services received by your child and/or your family.**

My child has been previously evaluated by a medical and/or mental health professional (check one):

___ no

___ yes (list):_____

I will not contact any professional who has worked or is working with your child without signed permission of BOTH parents on a separate Release of Information Consent Form.

FEES AND PAYMENT

I am "fee for service," which means that **you are responsible for payment at the time services are provided** and I will not bill your insurance company directly. I will provide you with an invoice ("super bill") that includes the CPT codes, diagnostic codes, and NPI number that you can submit to your insurance at the out-of-network rate, if applicable. I urge you to contact your insurance company in advance of our appointments to determine whether they will cover counseling/therapy, and if so, under what conditions. Please note that some insurance companies require "preauthorization" in order to provide any reimbursement for services rendered.

I charge **$150 per 60-minute session** for my services. ***Payment is due at the time of service and you are directly responsible for payment of the fees to which we have agreed.*** Any exceptions to this payment policy (e.g., a payment schedule in the case of financial hardship) must be discussed with me in advance.

There is a $15 charge on all returned checks. Delinquent accounts will be referred for collection (the minimum amount of information necessary will be released in order for the collection agency to secure payment).

ACKNOWLEDGEMENT

I have reviewed the information in this agreement and have had my questions answered to my satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement. I consent to have my child participate in counseling/therapy with Dr. Mott.

Signature of Parent/Guardian (MATERNAL)	Date
Name (Please Print)	Relationship to youth
Signature of Parent/Guardian (PATERNAL)	Date
Name (Please Print)	Relationship to youth

NOTICE: The Department of Consumer Affairs receives questions and complaints regarding the practice of psychology. If you have any questions or complaints, you may contact this department by calling: (866) 503-3221 or (916) 574-7720 or by email (bopmail@dca.ca.gov) or by writing to the following address: Board of Psychology / 1625 North Market Blvd., Suite N-215 / Sacramento, CA 95834.

Updated 12/23/19

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Child's Name:_____ **Date of Birth**:_____

HIPAA NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD PROTECTED HEALTH INFORMATION (PHI).

By law I am required to ensure that PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you or your child. It contains data about past, present, or future health or condition, the provision of health care services, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it on my website (www.drmott.com.) You may also request an updated copy of this Notice from me.

III. HOW I WILL USE AND DISCLOSE PHI.

I will use and disclose PHI for many different reasons. Some of the uses or disclosures will require prior written authorization, but others will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Prior Written Consent. I may use and disclose PHI without your consent for the following reasons:

- ✓ For treatment. I can use PHI within my practice to provide mental health treatment, including discussing or sharing PHI with my trainees and interns (if applicable). I may disclose PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you or your child with health care services or are otherwise involved in your or your child's care. For example, if a psychiatrist is treating you or your child, I may disclose PHI to her/him in order to coordinate care.
- ✓ For health care operations. I may disclose PHI to facilitate the efficient and correct operation of my practice. For example, I might use PHI in the evaluation of the quality of health care services that you or your child have received or to evaluate the performance of the health care professionals who provided those services (i.e., for Quality Control). I may also provide PHI to my at-

torneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

- ✓ To obtain payment for treatment. For example, I might send PHI to your insurance company or health plan in order to get payment for the health care services that I have provided. Although I do not currently use a billing service, in the future I might provide PHI to business associates such as billing companies, claims processing companies, and others who may process health care claims for my office.
- ✓ Other disclosures. Your consent is not required if you or your child needs emergency treatment, provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose PHI without your consent or authorization for the following reasons:

- ✓ When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. For example, I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
- ✓ If disclosure is compelled by a party to a proceeding before a Court of an administrative agency pursuant to its lawful authority.
- ✓ If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
- ✓ If disclosure is compelled by the client or the client's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
- ✓ To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to medications).
- ✓ If disclosure is compelled or permitted by the fact that you or your child are in such mental or emotional condition as to be dangerous to self or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
- ✓ If disclosure is mandated by the California Child Abuse and Neglect Reporting law. For example, I may disclose PHI if I have a reasonable suspicion of child abuse or neglect.
- ✓ If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law. For example, I may disclose PHI if I have a reasonable suspicion of elder abuse or dependent adult abuse.
- ✓ If disclosure is compelled or permitted by the fact that you or your child tell me of a serious/imminent threat of physical violence by you or your child against a reasonably identifiable victim or victims.
- ✓ For public health activities. For example, in the event of your or your child's death, if a disclosure is permitted or compelled, I may need to give the County Coroner PHI information.
- ✓ For health oversight activities. For example, I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.

- ✓ For specific government functions. For example, I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
- ✓ For research purposes. Although I do not currently conduct research, in the future and under certain circumstances, I may provide PHI in order to conduct research.
- ✓ For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.
- ✓ Appointment reminders and health related benefits or services. For example, I may use PHI to provide appointment reminders. I may use PHI to provide information about alternative treatment options, or to provide information about other health care services or benefits I offer.
- ✓ If an arbitrator or arbitration panel compels disclosure, such as when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records), or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
- ✓ If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. For example, I may release PHI when compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
- ✓ If disclosure is otherwise specifically required by law.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

- ✓ Disclosures to family, friends, or others. I may provide PHI to a family member, friend, or other individual who you indicate is involved in your care or your child's care, or who is responsible for the payment for your or your child's health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any PHI. Even if you have signed an authorization to disclose your or your child's PHI, you may later revoke that authorization in writing to stop any future uses and disclosures of PHI by me (assuming that I haven't taken any action subsequent to the original authorization).

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR OR YOUR CHILD'S PHI?

A. The Right to See and Get Copies of Your or Your Child's PHI. In general, you have the right to see your or your child's PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have the PHI but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request; if I do, I will give you the reasons for the denial in writing. I will also explain your right to have my denial reviewed.

If you ask for copies of your or your child's PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it and you agree to the cost in advance.

B. The Right to Request Limits on Uses and Disclosures of Your or Your Child's PHI. You have the right to ask that I limit how I use and disclose PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. **The Right to Choose How I Send Your or Your Child's PHI to You.** It is your right to ask that PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI in the format you requested without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

D. **The Right to Get a List of the Disclosures I Have Made.** You are entitled to a list of disclosures of your or your child's PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years, or for seven years after your child turns 18.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. **The Right to Amend Your or Your Child's PHI.** If you believe that there is some error in the PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to the PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to the PHI.

F. **The Right to Get This Notice by Email.** You have the right to get this notice by email. You have the right to request a paper copy of it as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES.

If in your opinion, I may have violated your or your child's privacy rights, or if you object to a decision I made about access to PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C., 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you or your child.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Mariam A. Mott, Ph.D., 28562 Oso Parkway, Suite D-437, Rancho Santa Margarita, CA, 92688. My office/cell phone is (949) 858-6688. You can also email me at drmott@drmott.com, although the contents of email communications cannot be completely assured.

VII. NOTIFICATIONS OF BREACHES.

In the case of a breach, I (Mariam A. Mott, Ph.D.) am required to notify each affected individual whose unsecured PHI has been compromised. Even if such a breach was caused by a business associate, I am ultimately responsible for providing the notification directly or via the business associate. If the breach involves more than 500 persons, OCR must be notified in accordance with instructions posted on its website. I bear the ultimate burden of proof to demonstrate that all notifications were given or that the impermissible use or disclosure of PHI did not constitute a breach and must maintain supporting documentation, including documentation pertaining to the risk assessment.

VIII. PHI AFTER DEATH.

Generally, PHI excludes any health information of a person who has been deceased for more than 50 years after the date of death. I (Mariam A. Mott, Ph.D.) may disclose deceased individuals' PHI to non-family members, as well as family members, who were involved in the care or payment for healthcare of the decedent prior to death; however, the disclosure must be limited to PHI relevant to such care or payment and cannot be inconsistent with any prior expressed preference of the deceased individual.

IX. INDIVIDUALS' RIGHT TO RESTRICT DISCLOSURES; RIGHT OF ACCESS.

To implement the 2013 HITECH Act, the Privacy Rule is amended. I (Mariam A. Mott, Ph.D.) am required to restrict the disclosure of PHI about you or your child to a health plan, upon request if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law. The PHI must pertain solely to a healthcare item or service for which you have paid the covered entity in full. (OCR clarifies that the adopted provisions do not require that covered healthcare providers create separate medical records or otherwise segregate PHI subject to a restrict healthcare item or service; rather, providers need to employ a method to flag or note restrictions of PHI to ensure that such PHI is not inadvertently sent or made accessible to a health plan.)

The 2013 Amendments also adopt the proposal in the interim rule requiring me (Mariam A. Mott, Ph.D.) to provide you a copy of your or your child's PHI if you request it in electronic form. The electronic format must be provided to you if it is readily producible. OCR clarifies that I must provide you only with an electronic copy of your/your child's PHI, not direct access to your/your child's electronic health record systems. The 2013 Amendments also give you the right to direct me to transmit an electronic copy of PHI to an entity or person designated by you. Furthermore, the Amendments restrict the fees that I may charge you for handling and reproduction of PHI, which must be reasonable, cost-based and identify separately the labor for copying PHI (if any). Finally, the 2013 Amendments modify the timeliness requirement for right of access, from up to 90 days to 30 days with a one-time extension of 30 additional days.

X. NPP.

Most uses and disclosures of psychotherapy notes (if applicable), marketing disclosures, and sale of PHI require prior authorization by you, and you have the right to be notified in case of a breach of unsecured PHI.

XI. EFFECTIVE DATE OF THIS NOTICE.

This version of this notice went into effect December 23, 2019.

I acknowledge receipt of this notice:

_____ _____

Signature of Parent/Guardian (MATERNAL) Date

_____ _____

Signature of Parent/Guardian (PATERNAL) Date *Updated 12/23/19*

Mariam A. Mott, Ph.D.
Licensed Clinical Psychologist • PSY 16181

office: (949) 858-6688 email: drmott@drmott.com website: www.drmott.com

Child's Name:_____ **Date of Birth**:_____

YOUTH COUNSELING AGREEMENT

I have asked (or someone has asked me) to meet with Dr. Mott so that we can work together to solve certain problems. I understand that Dr. Mott may be talking with my parents, teachers, and other people who know me so that she can understand how best to help me. Counseling may help me feel better, behave better, get along better with others, and/or feel better about myself. In the process of working in these areas, I may experience uncomfortable feelings like anger, sadness, frustration, worry, etc. I understand that there are no guarantees about how much or how quickly I will get better. If I decide I don't want to work with Dr. Mott anymore, she will help me find someone else who can help me. If she thinks it will help, Dr. Mott may suggest other people who can also work with me and/or my family.

I will usually meet with Dr. Mott once per week until we have met our goals. I can ask to see her more than once per week if she has time and if my parents agree. Dr. Mott will not tell anyone except my parents (and other people who need to know) about our meetings.

In general, the things I tell Dr. Mott will be private, unless she decides that she must tell someone else. I understand that Dr. Mott's first job is to make sure that everyone is safe. She is required by law and by the standards of her profession to tell others if she thinks that a child or older person is being hurt in some way, or if someone may be a danger to themselves or others. Dr. Mott may also decide to tell my parents if I am involved in dangerous activities (e.g., alcohol or drug use, suicidal thoughts, etc.). In most legal proceedings, assessment information is protected. However, information may need to be shared during certain Court proceedings.

I understand that my parents may have a legal right to see my counseling records, but Dr. Mott has asked them to accept general information about our work together instead so that I can feel comfortable discussing private matters.

If I need to reach Dr. Mott, I can call her at **858-MOTT (6688)** or email her at drmott@drmott.com. I understand that the confidentiality of email communication cannot be 100% guaranteed.

_____ _____

Child's Signature Date

_____

Child's Name (Please Print) *Updated 12/23/19*