Mariam A. Mott, Ph.D.

Licensed Psychologist #16181

Office: (949) 858-MOTT Fax: (949) 858-6986 e-mail: drmott@drmott.com web site: www.drmott.com

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

PARENT COUNSELING AGREEMENT

This document contains important information about my counseling services and business policies. Please read this information carefully, and make note of any questions you have so they can be discussed with me.

BENEFITS, RISKS, AND ALTERNATIVES TO TREATMENT

You have been given this document because you are requesting counseling (also known as therapy) services for ____ _____ (name of 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 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 me for clarification. If for any reason you wish to seek services elsewhere, I will help you locate another mental health professional whenever you request it.

HOURS/AVAILABILITY/CONTACT INFORMATION

Counseling will be conducted during normal business hours, Mondays through Fridays. Exceptions to typical counseling times can be arranged with advanced notice. Counseling sessions will take place 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. Should you need to change your scheduled appointment time, please call me AT LEAST 24 HOURS IN ADVANCE. I can also be reached via e-mail at drmott@drmott.com, although the confidentiality of e-mail communications cannot be guaranteed.

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.

CONFIDENTIALITY 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. Consequently, I usually do not share the specifics of counseling sessions with parents, although I will provide you with general information about your child's progress. I may 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 may be legally entitled to receive a copy of your child's records. Because of the importance of trust in the counseling relationship, however, 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 in my presence so that you can discuss the contents. Alternatively, I can send the summary to another 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 counseling (although certain court proceedings, actions before the Board of Psychology, or other illegal activity may limit the ability to maintain confidentiality). By signing this form, you agree that you will not attempt to gain advantage in any legal proceeding between the two of you from my involvement with your child. In particular, neither of you will ask me to testify in court, either in person or by affidavit. You also agree to instruct your attorney not to subpoena me or to refer in any court filing to anything I have said or done. Please note 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.

RELEASE OF INFORMATION

In order to more completely understand and work with your child, it will most likely 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 details): _____

Please be aware that I will not contact any professional who has previously worked with your child without signed permission of BOTH parents on a separate Release of Information Consent Form.

CONTACTING DR. MOTT

I can be reached via e-mail at drmott@drmott.com, although the confidentiality of e-mail communications cannot be guaranteed. I can also be reached through my office at **(949) 858-MOTT (6688)**. If you are unable to reach me and feel like you can't wait for a return call, contact your family physician or the nearest emergency and ask for the psychologist or psychiatrist on call.

FEES AND PAYMENT

I am "fee for service," meaning that you are responsible for payment and I will not bill your insurance company directly. I will provide you with an invoice ("super bill") that includes the necessary CPT codes, diagnostic codes, and NPI number that you can submit to your insurance. **I urge you to contact your insurance company in advance of our appointment to determine whether they will cover counseling, 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 **$150.00 per 60-minute session** for my services. ***Payment is due at the time of service.*** Please be aware that ***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) can be discussed with me in advance. ***It is your responsibility to check with your individual insurance carrier to determine whether or not they cover counseling services***. I will not bill your insurance company, but I will provide you with an invoice for you to submit for reimbursement. There is a $15.00 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 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) 5033221 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.

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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. In most legal proceedings, information about counseling 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. She has done this because it is important for me to feel comfortable discussing private matters. Dr. Mott may decide to tell my parents if I am involved in dangerous activities (e.g., alcohol or drug use, suicidal thoughts, etc.).

If I need to reach Dr. Mott, I can call her at **858-MOTT (6688)** or e-mail her at drmott@drmott.com. I understand that e-mail communications may not be confidential.

_____ _____

Child's Signature Date

_____

Child's Name (Please Print)