Consent for Psychotherapy for a Minor

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

I, _____, hereby give full consent for my child, _____ to receive the services of Otito Omeludike, PMHNP-BC, APRN until I notify her or she determines that services are no longer appropriate or will no longer be provided. I understand the first session with Omeludike, PMHNP-BC, APRN is a consultation only. This consultation is for an evaluation of my child's mental health. It may take more than one session to complete the evaluation. I understand formal treatment is not initiated until Otito Omeludike, PMHNP-BC, APRN and I agree to do so.

I authorize Otito Omeludike, PMHNP-BC, APRN to carry out the psychological assessments and treatments which are advisable during my child's psychotherapy. I understand that while the assessment and treatment is designed to be helpful and beneficial, it may be at times difficult and uncomfortable. There is an expectation that my child will benefit from the assessment, but there is no guarantee this will occur. I also understand that the nature of psychotherapeutic treatment includes the possibility that symptoms may worsen before improving, and that there's no guarantee of a cure.

Confidentiality

I understand Otito Omeludike, PMHNP-BC, APRN regards the information my child shares with her as most confidential, and that she honors the right to privacy. I understand she adheres to what she believes to be a much more stringent set of confidentiality guidelines than those provided by the State of Texas or the federal department of Health and Human Services. Specifically, I understand Otito Omeludike, PMHNP-BC, APRN is required to disclose confidential information without my consent under certain circumstances that include but are not limited to the situations listed below. Should disclosure be necessary, Otito Omeludike, PMHNP-BC, APRN will make every reasonable effort to inform me of this disclosure.

- If my child is evaluated to be a danger to themselves or others;
- If Otito Omeludike, PMHNP-BC, APRN believes my child is the victim of abuse or if they divulge information about abuse;
- If my child divulges information which would cause Otito Omeludike, PMHNP-BC, APRN to reasonably believe that my child has abused a minor, an elderly or disabled person, or a member of another protected class;
- If I file a suit against Otito Omeludike, PMHNP-BC, APRN for malpractice;
- If there is a court order, other legal proceedings, or statute that requires disclosure;
- If Otito Omeludike, PMHNP-BC, APRN is required to report certain professional ethical situations, she will abide by Texas laws
- I further acknowledge that a third-party payer may have limited access to otherwise confidential information.

If the course of therapy reveals any intent by my child to harm either themselves or others, I acknowledge Otito Omeludike, PMHNP-BC, APRN's legal and moral duty to prevent my child from bringing this harm about. I specifically give my irrevocable permission to warn those parties she feels may be harmed. If my child reveals an

intent to harm themselves, Otito Omeludike, PMHNP-BC, APRN has my permission, irrevocable, to prevent them from accomplishing any intent.

Records

I understand it is stated law that licensed professional counselors maintain a record of the treatment given to my child. This record will contain the information that will allow Otito Omeludike, PMHNP-BC, APRNto chart the course of therapy. She will use it only for that purpose. It is her intent that no one will ever see what is contained in the file. I understand I may get a copy of the file only by providing her with a signed release of information request. Otito Omeludike, PMHNP-BC, APRN may provide me with a synopsis of the course of treatment and outcome in lieu of the actual record. I agree I will pay in advance for either the copying cost of the actual record or the time required for the preparation of the treatment summary. This includes providing copies or reports to any court or legal representative or designate. If the therapy sessions contain more than one patient, I agree that no one person may get the complete treatment file. I agree with Otito Omeludike, PMHNP-BC, APRN may summarize the course of everyone's treatment as opposed to providing a copy of what notes may have been made during any therapy session.

If I have or plan to file for reimbursement with a managed care or an insurance company, I am aware that she may have to waive my right to confidentiality as it pertains to the managed care or insurance company. I am aware that the organization is not bound by her ethical and legal requirements on maintaining the confidentiality my treatment may require. Once these records are in the possession of the managed care or insurance company, Otito Omeludike, PMHNP-BC, APRN cannot guarantee their continued confidentiality.

Termination of Treatment

I understand the length of time required for therapy will be determined by my child's personal situation. I understand Otito Omeludike, PMHNP-BC, APRN will do her best to fulfill their therapeutic needs and to provide him/her with her best professional care. For my part, I agree to participate in the process of supporting my child to the best of my ability. It is intended that when my child's needs are met, to the extent that they can be, we will terminate our relationship.

I understand for my part; I may terminate treatment at any time. This may be accomplished in any one of several ways. This includes, but are not limited to, putting it in writing, informing me verbally, failing to maintain appointment schedule without proper notification, or failure to follow treatment recommendations. I understand Otito Omeludike, PMHNP-BC, APRN will respect my wishes to terminate treatment. I also understand the method I choose to accomplish termination will impact any decision to resume a therapeutic relationship with her.

My signature on this consent form verifies that I have had the opportunity to ask questions regarding procedures, policies, and therapeutic techniques. I verify that all my questions were answered to my satisfaction by Otito Omeludike, PMHNP-BC, APRN; and that I voluntarily give my consent for treatment. I understand that I have the right to withdraw my consent for treatment at any time.

Payment

I understand payment is due at the time of service. Payment schedule is as follows:

- $225 for an initial intake and assessment (60 minutes)
- $175 for individual adult sessions (60 minutes)
- $150 for individual or Play Therapy sessions (45 minutes)
- $100 for individual or Play Therapy sessions (30 minutes)
- $75 per session for Group Therapy (60 minutes)

Rates for other services:

- $1.00 per page for Copying Records
- Legal Fees: Phone time, letter writing, court appearances, travel, $300 per hour

Fees for Services

All fees are payable at the time services are rendered. Payment may be made using cash, check, Visa, Mastercard, and Discover. I understand if I do not uphold my responsibility to pay for services, this may result in the termination of treatment with Otito Omeludike, PMHNP-BC, APRN and referral or treatment services elsewhere with appropriate notice provided. **Initial** _____

If I need to cancel a session with Otito Omeludike, PMHNP-BC, APRNI agree to provide at least 24-hour notice. If my child's session is on Monday, notification will need to be given on the Friday before the appointment. If I do not provide this notice, I understand I will be billed the full amount of the therapy session. No-show appointments will also be charged the full fee. **Initial** _____

A credit card must be kept on file and will be charged for no-show and late cancel appointments.
Initial _____

A Superbill can be provided to clients for reimbursement by insurance companies when requested by the parent. Each insurance carrier has a different policy for out-of-network benefits; please contact your insurer for your policy reimbursement. **Initial** _____

DISCLOSURE STATEMENT: I am licensed by the Texas State Board of Nursing and follow all of the ethical guidelines. If you feel that I have provided services that are unethical or conflict with our licensing standards, complaints regarding services may be made with the licensing board. Address: George H. W. Bush State Office Building, 1801 Congress Avenue, Suite 10-200, Austin, TX 78701. (512) 305-6838
https://complaints@bon.texas.gov/

Your signature indicates that you have read, understood, and agree with the policies above.

_____ _____

Signature Name Parent/Guardian Date