Comprehensive Mental Health
13341 US 290 BLDG 1-103, Austin Texas 78737
contact@comp-mh.com

Informed Consent for Children & Adolescents for therapy

GENERAL INFORMATION

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how the therapy relationship will work with your child, and what everyone can expect. This consent will provide a clear framework for the play therapy or psychotherapy work with your child. Feel free to discuss any of this with your provider. Please read and indicate that you have reviewed this information and agree to it by signing at the end of this document.

THE THERAPEUTIC PROCESS

You have taken a very positive step by deciding to seek therapy for your child. The outcome of your child's treatment depends on many different factors, including child's sense of comfort, willingness to participate and caregiver support and involvement. Your child's counselor may utilize a variety of treatment modalities based on the individual needs of each client. These modalities and techniques may include play therapy, cognitive behavioral, person-centered, and solution-focused therapies. Your child's therapist will meet with you individually to discuss which treatment approach will benefit the child most. It is important that parents/caregivers take an active role in the consultation process and feel comfortable sharing thoughts and feelings about the fit of therapy. If you have any concerns about this being the correct treatment option for your child, we are more than happy to discuss referral options and other treatments that may be of help to your family.

If parents share joint legal custody of a minor under the age of 14, both parents are entitled to disclosures about the therapeutic process including information about goals, progress, and themes in therapy. Minors over the age of 14 are allowed to seek counseling services without the consent of a parent. When a minor over the age of 14 is being treated, the therapist and child will work together to determine how much information will be shared with parents.

CONFIDENTIALITY

Confidentiality in the counseling relationship is an important aspect of building trust and rapport. Confidentiality includes not only what is said in the counseling session, but also physical documents such as artwork or any photography of artwork in the clinical file. Parents have the right to discuss general information such as themes, progress, and goals within therapy. Information pertaining to the child or his/her record will not be released to anyone other than a custodial parent without a signed release of information. In cases of joint legal custody, the parent requesting therapy is responsible for informing the other party. Both parents are entitled to information and are invited to participate in the therapeutic process.

The session content and all relevant materials to your child's treatment will be held confidential to third parties unless you as the parent request in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.

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3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Confidential or sensitive information is not appropriate to be discussed in the lobby. If you would like to discuss your child's therapy, please schedule a parent consultation with your therapist.

Occasionally we may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using you or your child's name. If we see each other accidentally outside of the therapy office, with or without your child, we will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to us, and we do not wish to jeopardize your privacy. However, if you acknowledge us first, we will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

APPOINTMENTS

The first session (sometimes referred to as the intake session) will involve a comprehensive evaluation of your child's needs. After the intake session, your provider will be able to offer you some initial impressions of what services might include. You should evaluate the assessment information and make your own determination about whether you feel comfortable working with your child's provider for future sessions. After the intake session, you and your provider will agree upon the frequency of sessions. Session duration is determined ahead of time, and sessions are scheduled ahead of time. The time scheduled for your appointment is assigned to only your child. If you need to cancel or reschedule a session, please provide notice 24 hours in advance. You will be charged a full session fee for late cancellation/no-show if notification is not provided 24-hours prior to the scheduled session time. Insurance does not cover late session fees; your credit card on file will be charged the late cancellation fee.

We recommend that children attend therapy in comfortable clothing that may get messy occasionally. Art materials utilized will be chosen specifically for their ability to wash out of clothing easily. If your child is sick, please keep them home from therapy. Sick children are unable to fully engage in therapy, and it is appreciated if you keep them home.

Termination: It is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. Treatment may be terminated after appropriate discussion if it is determined that psychotherapy is not being effectively used, or if you are in default on payment. The therapeutic relationship will not be terminated without first discussing the reasons and purpose of termination. Your provider will provide referrals should you initiate termination for whatever reason. Should you fail to schedule an appointment for three consecutive weeks (unless other arrangements have been made in advance), for ethical and legal reasons the professional relationship will be terminated; your spot on CMH's caseload will be forfeited and your client file will be closed. You are always welcome to resume services with CMH should you wish, pending caseload availability.

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TELEPHONE ACCESSIBILITY
If you need to contact your provider between sessions, please leave a message by calling the clinic. We will attempt to return your call within 24 business hours. If a true emergency situation arises, please call 911 or any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION
Due to the importance of your confidentiality and the importance of minimizing dual relationships, providers do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of the therapeutic relationship. If you have questions about this, please bring them up when you meet with your provider and we can talk more about it.

ELECTRONIC COMMUNICATION
We cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email for issues regarding scheduling or cancellations, we can do so; we do not have capacity for texting. While I may try to return email messages in a timely manner, we cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

RISK/BENEFITS OF THERAPY
Therapy has both benefits and risks. Benefits of therapy may include mood regulation, improved communication, improved functioning at home/school, and integration of difficult or troubling experiences. We often tell parents that at first, it may seem as if things are getting worse before they get better. Within the first few sessions, you might see an increase in behaviors such as tantrums, emotional outbursts, sadness/crying, etc. If you notice these changes in your child, please communicate them with their counselor. If your child is close to termination of counseling, we recommend scheduling at least 3 final sessions to transition successfully out of the counseling relationship.

CONSENT
I have read and understand the client rights and responsibilities statement. I acknowledge that the client rights and responsibilities have been explained to me and my questions have been answered to my satisfaction. I agree to comply with the above information, and to give my informed consent to my clinician to evaluate and consult on care and treatment for my child. I acknowledge that I was provided with the notice of privacy practices and that I have read (or have had the opportunity to read) if I so chose. I further acknowledge that I have been informed and understand that this informed consent may be revoked at any time by clearly communicating such revocation to your child's counselor.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

CHILD'S NAME: _____

PARENT/GUARDIAN'S NAME: _____

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PARENT/GUARDIAN'S SIGNATURE: _____

DATE: _____

TELEMEDICINE CONSENT

While virtual sessions can be a productive format for adults, the effectiveness of play therapy or talk therapy for older children if often diminished on a virtual platform. For this reason, your therapist will not offer virtual sessions for young children.

In rare circumstances your therapist may accommodate a request for a virtual session based on extenuating circumstances and current progress in therapy. The following applies in these instances-

Telemedicine services may be offered as sole or partial treatment. Telemedicine services involve the use of audio, live video (like Skype, Zoom, Etc.,), or other electronic communications to interact with you for the purpose of providing medical care, and/or follow-up services on an individual basis. A potential risk of telemedicine is that your specific concerns, or unforeseen technical issues, may still necessitate a face-to-face session as part of your ongoing treatment.

Additionally, in rare circumstances security protocols could fail causing a breach of patient privacy. All laws concerning patient access to medical records and copies of medical records apply to telemedicine. You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consultation without affecting your right to future care or treatment. The alternative to telemedicine is a face-to-face visit with a clinician.

I do hereby consent to allow my provider to record any or all parts of my telehealth session(s). This includes video and/or audio recording of any conversations, consultations and virtual treatments/office visits.

I understand that the recordings of my telehealth sessions and virtual communications are for the sole use of my treatment and medical documentation and will not be used in any marketing or advertising; nor will they be used as patient testimonials without my express written consent.

I understand that I have a right to request copies of such recordings and have the right to revoke this authorization in writing at any time during the course of my treatment.

I understand that this
authorization will remain in place in perpetuity, or until such time as I revoke the authorization in writing.

CHILD'S NAME: _____

PARENT/GUARDIAN'S NAME: _____

PARENT/GUARDIAN'S SIGNATURE: _____

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DATE: _____

NOTICE OF PRIVACY PRACTICES
EFFECTIVE DATE OF THIS NOTICE
This notice went into effect on 02/19/2023.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you and describe certain obligations I have regarding the use and disclosure of your health information.

I am required by law to:

• Make sure that protected health information ("PHI") that identifies you is kept private.

• Give you this notice of my legal duties and privacy practices with respect to health information.

• Follow the terms of the notice that is currently in effect.

• I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information or each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition. Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes,

among other things, the coordination and management of health care providers with a third party, consultations between health care
providers and referrals of a patient for health care from one health care
provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

a. For my use in treating you.

b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or
individual counseling or therapy.

c. For my use in defending myself in legal proceedings instituted by you.

d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

e. Required by law and the use or disclosure is limited to the requirements of such law.

f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.

g. Required by a coroner who is performing duties authorized by law.

h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

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5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who
received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United
States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10 Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made. You
have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will

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provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

CHILD'S NAME: _____

PARENT/GUARDIAN'S NAME: _____

PARENT/GUARDIAN'S SIGNATURE: _____

DATE: _____