Janice Brown-Silveira, Licensed Marriage and Family Therapist
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Office Practices and Consent to Treatment Form for Minors

As a Marriage and Family Therapist, it is important to me that my clients are fully informed regarding my office practices and their rights regarding mental health treatment. The following information is important for you to know now that you are considering utilizing psychotherapy services. We will review these issues in our initial meeting. If you have questions regarding any of these topics, or others, please feel free to ask me.

1) Therapy Sessions

Generally, sessions will take place in my office at 1325 Airmotive Parkway. Sessions will last 50 minutes unless other arrangements are made. When clinically warranted and appropriate, we can schedule meetings in your home, on the phone, at school, or in the community. Other family members and professionals working with your family may also be included in your child's treatment. If any of these types of sessions seem appropriate, we must, and will, discuss them fully beforehand, including any additional fees that may apply. It is expected that sometimes events will occur that will make it impossible for your child to attend a scheduled session. If this should happen, please call to cancel no later than 24 hours before the session. If you do not call and your child does not attend the session you will be charged a "no show" fee. This fee will be set in our initial session.

2) Limits of the Therapy Relationship

Therapy is a professional service I can provide to your family. Because of the nature of therapy, my relationship to your family has to be different from most relationships. It may differ in how long it lasts, in the topics we discuss, or in its goals. It must also be limited to the relationship of therapist and client *only*. While it is certainly my hope and intention that we will have a warm and friendly relationship, there are important differences between the therapy and other relationships. You should know that therapists are required to keep the identity of their client's secret. Therefore, I may not acknowledge you or your child when we meet in a public place, and I would be unable to attend family or school functions. Additionally, when our therapy is completed, I will not be able to be a friend to your family like other friends. In sum, my duty as a psychotherapist is to care for your child, but *only* in my professional role.

3) Confidentiality

Confidentiality is vital to a therapy relationship. Confidentiality means that I will not reveal any information about your family (including that you are my clients) to any other individual or organization without your explicit permission. However, there are important legal limitations to confidentiality that you should be aware of. I am legally required to break confidentiality under the following conditions:

- If a member of your family informs me of any child abuse or elder abuse.
- If a member of your family gives me reason to believe that they would be a danger to themselves or someone else.
- If your family becomes involved in a legal proceeding and a valid court order is issued instructing me to provide confidential information about treatment to the court.

It is very important that your child feel that therapy is a safe place where they can share their thoughts, and feelings. I do not believe that it is possible to create this safe place if your child feels that I am reporting back to you concerning things that they may share in their work with me. At the same time, I recognize a parent's natural concern for their child's well-being and progress in treatment. Therefore, you can expect that I will provide you with general updates regarding your child's progress any time you wish, but I will not inform you of any specifics that your child may share with me in our sessions. This includes behaviors about which many parents would be concerned (i.e. stealing, skipping school, drug use, lying). You should know, however, that if your child informs me of any behavior or events that pose an imminent danger of severe physical harm to themselves or others (i.e. victim of severe bullying, drunk driving, suicidal statements), I will inform you as quickly as possible. Your signature below indicates that you accept the above statements and are willing to allow me and your child to determine what you are told about the content of therapy sessions.

If you have any questions regarding my policy in this matter please feel free to ask.

_____ (Signature indicates acceptance of minor holding the privilege)

If you are a single parent, you should know that ethical, legal, and clinical considerations may make it necessary for us to contact your child's other parent and obtain their consent for your child to receive services. If this is necessary, we will discuss how to make contact with the other parent and we will do so together. I will not initiate any contact with any other member of your child's family without your explicit permission. If you have court documents relating to the custody of your child, please be prepared to bring them in as soon as possible. You should be aware that non-custodial parents are entitled to access to their child's treatment records under the law.

You should be aware that I use a billing service with Tami Burkett, to obtain payment for services and to track my client's payments. Tami Burkett has an established billing service in our community and has signed a confidentiality agreement with me in the interests of protecting your privacy. In order to facilitate billing activities, some information regarding our relationship will be related to others, for example, banks or insurance companies, depending upon how you intend to pay for services. Additionally, if it becomes necessary for me to use a collection agency to obtain payment, information about your identity and our relationship would need to be shared with the agency. Please know that it is of the highest importance to me to protect your family's privacy. When it is necessary to share confidential information, know that I will share ONLY the information necessary, and that I will always attempt to inform you prior to any compromise of your confidentiality.

Please also be aware, that any electronic transmission of information between my office and you or your insurance company, whether by cell phone, e-mail, or FAX machine poses a risk to your privacy. These devices are not secure and I have no control over information transmitted by these means. This information is potentially available to anyone with the ability to retrieve it.

I HAVE READ JANICE BROWN-SILVEIRA'S CONFIDENTIALITY POLICIES AND HAVE HAD THEM FULLY EXPLAINED TO ME. MY SIGNATURE BELOW INDICATES THAT I AUTHORIZE JANICE BROWN-SILVEIRA TO ELECTRONICALLY TRANSMIT INFORMATION.

Signature_____

4) Child Safety Issues

The safety and well-being of your child is of the utmost importance. In the interests of your child's safety, you are invited to remain in the waiting room while your child is having their session. You may use this as a time for yourself to relax from the pressures of the day. If there is anything that would make the waiting room more comfortable for you, please let me know. If you must leave, it is vitally important that you be back on time to pick your child up from their session. There is no staff member available to watch your child if you are late, and I will need to remain with your child until you return, potentially inconveniencing and delaying other families. If you must leave, please make sure that I have a telephone number where you can be reached should an emergency arise. Please also let me know if a friend or other family member will be picking up your child after their session. I will not allow your child to leave with people who are strangers to me if arrangements have not been made ahead of time. If you require access to your child at any time during our session, please know that I have an "open door" policy. If you need to speak with your child simply come back to the therapy room door and knock.

5) Benefits and Risks

While no one can make a guarantee regarding the outcome of psychotherapy, over 50 years of carefully designed research have documented its effectiveness in addressing mental health and behavior issues and other life problems. During our initial sessions, we will directly discuss your goals for my work with your child, your child's goals, and my impressions of the degree to which my services can help both of you reach those goals. While little research has been done on the potential negative effects of psychotherapy, experience has shown that being in therapy can bring up painful emotions and memories, and may be disruptive to interpersonal relationships. It has been said that in therapy things may get worse before they get better. I will discuss any foreseeable concerns I have regarding therapy related risks with you and your child on an ongoing basis. I fully invite both of you to do the same. I encourage you to feel free to consult with me in person, by telephone, or by letter regarding therapeutic progress or any other concerns you may have.

6) Financial Issues

You and I will complete a separate financial agreement form as part of our initial session. Payment in full is expected at the time of each session. You have the option of paying by cash or check. If you are experiencing financial hardship, we can also discuss a "sliding scale" fee for my services. If I am not able to accept your health insurance, I can provide you with an itemized receipt for services that you can submit to your insurance company for reimbursement. While you must discuss any details regarding your coverage or reimbursement with your insurer, feel free to let me know if there is any other way that I can assist you in being reimbursed. If you plan on utilizing your insurance to pay for services, please note that you will be responsible for any non-authorized or non-covered services. Please be aware that if you fall 30 days behind in paying your bill, you will receive a reminder notice in the mail. If you fall 60 days behind we will need to discuss the situation by telephone or in person. If you fall 90 days behind, your account will be referred to a collection agency. However, you should know that before any such referral is made I will make every attempt to contact you to resolve the situation informally

7) Alternative Treatments

You should know that there are many different types of mental health treatment that you and your child may find helpful. There are a number of medical treatments that are believed to be effective in addressing emotional and behavioral concerns, as well as other psychological treatments, and alternative medicine. I will be happy to discuss any of these options with you and your child, to the degree that I am professionally able, to see if they would be useful for you to utilize in addition to, or instead of, my services. You should know that selecting a mental health professional to work with is a very personal process, and involves taking into account both your comfort with the service provider and your child's feelings about therapy. If you do not feel that you, your child, and I will be able to work together effectively, either now or in the future, I will be happy to assist you in locating a new therapist or an alternative method of addressing your family's concerns.

Name of child client: _____

Janice Brown-Silveira and I have discussed my child's situation. I have been informed of the risks and benefits of several different treatment choices and have had all my questions answered fully.

I do hereby seek and consent to take part in treatment with Janice Brown-Silveira, and give my consent for her to treat my child. I understand that discussing a treatment plan and regularly reviewing our work toward meeting the treatment goals are in my child's best interest. I agree to play an active role in this process. I will keep Janice Brown-Silveira fully up to date about any changes in my child's behaviors, and any significant changes in my family's functioning. I expect us to work together on any difficulties that occur, and to work them out in my child's long-term best interest. I also agree that therapy will be most beneficial if my child is allowed to have a confidential relationship with Janice Brown-Silveira. I understand that Janice Brown-Silveira will inform me if my child is in imminent, severe, physical danger and agree to allow Janice Brown-Silveira to determine when it is appropriate to inform me about the content of my child's sessions.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Janice Brown-Silveira.

I am aware that I may stop my child's treatment with Janice Brown-Silveira at any time. The only thing I will still be responsible for is paying for the services my family has already received. I understand that I may have to deal with other problems if I stop treatment. (For example, if my child's treatment has been court-ordered, I may have to answer to the court.)

This agreement shows my commitment to pay for Janice Brown-Silveira's services. It also shows her willingness to use and share her knowledge and skills in good faith. I understand and accept that I am fully responsible for my financial agreement with Janice Brown-Silveira, but that she will aid me in obtaining benefits from any insurance coverage I have. I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. I agree to pay a "no show" fee for uncancelled appointments or those where I fail to give enough notice that I will not attend. The only exceptions are unforeseen or unavoidable situations arising suddenly.

I am aware that Janice Brown-Silveira utilizes billing services through Tami Burkett and that information regarding the type(s), cost(s), date(s), and providers of any services or treatments my family receives will be shared with the

billing specialist so that they may bill for and/or track these services. I understand that if payment for the services I receive here is not made, that Janice Brown-Silveira may stop my treatment.

I understand that this agreement will become part of my child's record of treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client's representative Date

_____ _____

Printed name Relationship to client

_____ _____

Client's Signature Date

I, the therapist, have discussed the issues above with the minor's parent, guardian, or other representative. My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.