

Counseling & Expressive Arts Client Service Agreement

Minor Consent Form

This form outlines the counseling services provided, and the expectations of the provider and the client. It is intended to provide you with the information necessary to feel safe and supported in your decision to use psychotherapy and expressive arts therapy for your child.

Prior to beginning counseling services, it is important for you to understand my approach and agree to some guidelines about your child's confidentiality during the course of his/her treatment. Under HIPAA and the APA Ethics Code, I am legally and ethically responsible to provide you with informed consent.

CONFIDENTIALITY

Any information about your child and/or your child's artwork is held with utmost confidentiality and can only be released by either your written and signed consent or by court order.

CONFIDENTIALITY EXCEPTIONS

1. When a client may be a danger to him/herself or others I am obligated to keep everyone safe.
2. When there is a suspicion or disclosure of child abuse I am obligated to report.
3. When records are subpoenaed by court order.
4. When you give written permission to consult with other individuals / professionals, such as a doctor, psychiatrist, or therapist.

CONFIDENTIALITY & MINORS

Therapy is most effective when a trusting relationship exists between the therapist and the client. Privacy is especially important in securing and maintaining that trust. One goal of using counseling with minors is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about process and progress. I will not share with you what your child has disclosed to me without your child's consent. When information provided by your child may be useful for making healthy changes within home or school settings, I will encourage your child to disclose relevant information so that family and therapy goals can be better achieved, but at their own pace and discretion.

If your child is an adolescent, it is possible that he/she may reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Often these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. Behaviors that indicate the safety of your child or another person is at risk require exception to confidentiality and will be discussed with your child and with you.

By signing this form, you agree to my policy that children are entitled to privacy. While parents or guardians do have legal right to information, you agree to allow provider discretion in access to your child's counseling records.

THERAPIST RESPONSIBILITIES

To be prepared and on time for each session.

To provide a safe and supportive environment.

To respectfully balance parental goals with those of the minor client.

To keep all information and art work confidential.

To communicate clearly.

CHILD'S RESPONSIBILITIES

To be willing to show up for appointments.

To be open to trying the process of expressive arts in counseling.

To be honest.

PARENTAL RESPONSIBILITIES

To keep appointments by bringing the child on time and paying agreed upon fees at time of service.

To provide 24 hours notice if appointments need to be cancelled

To be open and trust the process of counseling and expressive arts.

To be honest.

Although my responsibility to your child may require my involvement in supporting your child through conflicts between parents/guardians, your agreement is that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither parent will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In any such proceedings, you agree that neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

My goal is to balance the needs and goals of your child with your goals and preferences. I will strive to listen carefully so that I can understand your perspectives. Should disagreement regarding my approach or procedures arise, you agree to resolve such disagreements in such a way that your child's progress is not negatively impacted. If you decide to terminate services, I have the option of having two closing sessions with your child to properly end the relationship.

APPOINTMENTS

- Appointments are scheduled through direct communications with me.
- If your child is unable to attend a session, it is your responsibility to inform me 24 hours in advance so that the time can be made available to others. Cancellations without 24 hour notice will be charged full fee.

PAYMENT

The standard session of 1 hour is available at a rate of \$75. The session of 1 ½ hours is available for \$120. All services are self-pay. Sliding scale rates of \$45-75 are determined on a case-by-case basis.

Payments of cash or check at the time of service. Invoices can be e-mailed or handed to client directly at client's request.

Super bills can be provided if the client is submitting to insurance for repayment. It is the responsibility of the client to confirm with their insurance that the provider is accepted through out of network benefits.

If appointments are not cancelled with 24 hours notice there will be a late cancel fee of \$50. If client does not show for an appointment client will be charged the full session fee of \$75.00

TECHNICAL AGREEMENT

You can contact me by e-mail or phone to confirm or change appointments or basic information. For confidentiality reasons, clinical questions will not be answered over e-mail and will be deferred to the next session.

GENERAL

You and your child will both be asked to outline your needs, goals, and the way you would like my support to improve emotional and mental health. Your child will be supported to work through challenging thoughts and feelings in a safe and age-appropriate manner. If you or your child has concerns or suggestions, please do not hesitate to address these with me so that I can further support you.

Expressive arts counseling uses a variety of art materials. It also may use movement, sound, drama, writing, or other activities. These may be used to prompt discussion, promote insight, develop skills, or otherwise achieve stated treatment goals.

CLIENT AGREEMENT

I have been informed of the above conditions and accept the terms of service for Psychotherapy/Expressive Arts Therapy. I have read, understand and agree with the above.

Child's Name: _____

Parent/Parents Name(s) _____

Address: _____

Phone &

Email: _____

Child's Signature:

Parent/Parents Signature(s):

Date: _____

Provider's Signature: _____

Date: _____