

## Office Policies and Consent for Treatment of a Minor

Welcome to my office. I am a Licensed Marriage and Family Therapist. I am trained to provide psychotherapy to adults, adolescents and children, and am governed by various laws, regulations and ethical standards. The Code of Ethics in my profession requires that I make you aware of specific policies. If you have any questions after reading this form, please bring them to my attention.

**Participation in Treatment:** This Agreement has been created for the purpose of outlining the terms and conditions of services to be provided by **Amy Hamilton, LMFT** for the minor child or children:

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(herein "Client") and is intended to provide [name of parent(s)/legal guardian(s)]

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(herein "Representative(s)") with important information regarding the practices, policies and procedures of **Amy Hamilton, LMFT** (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Client. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

**Policy Regarding Consent for the Treatment of a Minor Child:** Generally, I require the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of Representative to give consent for psychotherapy, I will require that Representative submit supporting legal documentation, such as a custody order, prior to the commencement of services.

**Appointments and Cancellations:** Psychotherapy sessions are 50 minutes long unless otherwise arranged in advance. If you are late for an appointment, I will see you for the remainder of your reserved time. Since scheduling a session involves reserving a time specifically for you, a minimum of 24 hours notice is required for rescheduling or canceling an appointment. Please note that you will be charged the full fee for missed sessions without such notification.

**Payment for Service:** All fees paid for services shall be paid to **Amy Hamilton, LMFT**. Fees may be paid by cash or personal check. It is customary to pay for services at the time they are rendered unless other arrangements have been made. Therapist reserves the right to periodically adjust this fee. Client will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payors, or by agreement with Therapist. As of the date of this contract, the agreed upon fee between Therapist and Client is

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**Insurance Reimbursement:** The Client is responsible for payment of all charges at the time of service. You may check with your insurance company to determine whether therapy costs are covered and to what extent. Confidential information will not be revealed to a third party payer without your permission. Please note that most insurance carriers do not reimburse for missed or canceled sessions.

**Telephone Accessibility:** I check messages regularly throughout the day and return calls as soon as possible. In the case of a true life-threatening emergency, please dial 911 or go to a local emergency room immediately. I am available to speak with you between sessions as needed. In the event that a lengthy telephone contact is required, you will be charged a full or pro-rated session rate.

**Safety:** To meet the professional standard of care, psychotherapists are expected to take reasonable steps to prevent suicide, and to attempt to ensure safety with the least possible violation of the Client's privacy and self-determination. If a Client makes a serious threat of physical violence to an identifiable victim, Therapist is required by law to notify the police and the intended victim. If Therapist has reason to

suspect that a child, elderly adult or dependent adult is being abused or neglected, Therapist is mandated by law to make a report to the appropriate agency.

**Confidentiality:** The information that you share with me during your therapy session is strictly confidential. This means that I will not release any information about you, including the fact that you are a Client, without your prior written consent. If a reason to share information with another party arises, you will be asked to sign a form authorizing me to do so. You may revoke this authorization at any time by written notice.

**Confidentiality of Minors:** The parent of a minor has a legal right to access information about his child’s treatment, unless otherwise stated by law. However, in order to facilitate effective treatment, this right must be balanced with the minor’s right to a confidential therapeutic relationship. The confidences of minors will be respected as deemed clinically appropriate, though safety concerns will take precedence over confidentiality when the two conflict.

**Electronic E-Mail Contact and/or Skype Sessions:** You are welcome to communicate with me via e-mail for any appointment requests and/or cancellations. However, if I am required to read any lengthy correspondence or other communication, or asked to provide any written reports or letters, these will be charged at a pro-rated fee. In addition, all Skype sessions will be billed at my regular fee.

**Professional Conduct:** It is the Therapist’s responsibility to avoid intentional or reckless harm to the client and to maintain appropriate boundaries. Sexual contact with a client is both a civil and criminal offense and should be reported to the California State Board of Behavioral Sciences.

**Termination of Services:** Participation in psychotherapy is strictly voluntary, and you may end treatment at any time you choose. The Client’s professional relationship with the Therapist continues as long as the Therapist is providing professional services, and until either the Client informs the Therapist that he or she wishes to terminate therapy, or the Therapist notifies the Client that therapy is being terminated. Assistance in making appropriate arrangements for continuation of services will be provided when necessary.

**I have read and understand all policies herein.**

\_\_\_\_\_  
Client Name (Print) C

\_\_\_\_\_  
Client Signature (if Client age 12 or over) C

As authorized Representative to Minor Client, I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

**I have read and understand all policies herein.**

\_\_\_\_\_  
Representative Name (Print) Relationship To Client

\_\_\_\_\_  
Representative Signature Date

### Client Information

Representative Name \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Email \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Please circle the number or numbers where you prefer to be contacted.

Your Education \_\_\_\_\_

Your Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Name

Phone

\_\_\_\_\_

Relationship to you

Minor Child Name \_\_\_\_\_

Parent's Name \_\_\_\_\_

Child's Address \_\_\_\_\_

\_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_

**Parent's Relationship Status:**

Married     Engaged     Cohabiting     Life Partners     Separated     Divorced

Widowed     Other \_\_\_\_\_

**Others Living with Child:**

Name	Relationship	Age
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Name	Relationship	Age
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Name	Relationship	Age
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Name	Relationship	Age
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Representative Name (Print)	Relationship To Client
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Representative Signature	Date
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