**Tompkins & Associates**

Licensed Clinical Psychologists

# Specializing in the Treatment of Children and Their Families

**Informed Consent for Psychotherapy**

**Minor**

Welcome to Tompkins and Associates. This document contains important information about professional services and business policies. Please read it carefully. When you sign this document, it will represent an agreement between Tompkins and Associates and you.

# **PSYCHOLOGICAL SERVICES**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you hope to address. There are many different methods I may use to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. At the end of the evaluation, we will notify you if we believe that we are not the right therapist for you and, if so, will give you referrals to other practitioners whom we believe are better suited to help you. If you have questions about office procedures, we should discuss them whenever they arise.

# **MEETINGS**

Clinicians normally conduct an evaluation that will last up to 2 sessions. During this time, the clinician will provide you with information regarding diagnostic impressions of the primary client and treatment planning and recommendations. Psychotherapy appointments are 45-60 minutes. Tompkins and Associates requires at least 48 hours notice of cancellations. If less than 48 hours notice is provided, a Late Cancellation Fee of $160 will charged to your account.

# **INSURANCE REIMBURSEMENT**

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Tompkins and Associates will electronically file claims for those insurance plans that we are able to bill. We will provide you with documentation to you for any out on network insurance claims and you are responsible for full payment of fees.

You should also be aware that most insurance companies require that we provide them with your clinical diagnosis. Sometimes we have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any records submitted, if requested. ***You*** ***understand that, by using your insurance, you authorize our office to release such information to your insurance company. We will try to keep that information limited to the minimum necessary.***

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above, unless prohibited by the insurance contract.

# **PROFESSIONAL FEES**

Out of pocket rates, prior to adjustments made based on your insurance coverage are:

The hourly fee for Intake Appointments is $250.

The hourly fee for 45 minute appointments is $130.

The hourly fee for 55 minute appointments is $160.

The hourly fee for psychological assessment is $175.

The hourly fee for additional professional services is $160. This fee is prorated as appropriate, based on the service provided. Other professional services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require our participation, you will be expected to pay for any professional time spent on your legal matter, even if the request comes from another party.

# **BILLING AND PAYMENTS**

You will be expected to pay for each session at the time of service, unless we agree otherwise or unless you have insurance coverage that requires another arrangement.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve billing the balance due to the credit card on file or hiring a collection agency. In most collection situations, the only information we will release regarding a patient’s treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

# **CONTACTING YOUR PROVIDER**

Psychologists and therapists are often not immediately available by telephone. Our phone is answered by our intake coordinator who can get a message to us quickly. You are welcome to leave a message for us at the office’s confidential line (630-717-5911) or you can contact via email. We will make every effort to return your call and emails within 2 business days. If you are difficult to reach, please inform us of some times when you will be available. If you are unable to reach us and feel that you cannot wait for a returned call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

## **CONFIDENTIALITY**

Parent Authorization for Minor’s Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify us immediately. We will ask you to provide a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child’s other parent, please be aware that it is our policy to notify the other parent that we are meeting with your child. We believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child’s treatment. If such disagreements occur, we will strive to listen carefully so that we can understand your perspectives and fully explain our perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child’s therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, we will honor that decision, unless there are extraordinary circumstances. However, in most cases, we will ask that you allow us the option of having a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with Provider

In the course of treatment with your child, we may meet with the child’s parents/guardians either separately or together. Please be aware, however, that, at all times, the patient is your child – not the parents/guardians nor any siblings or other family members of the child.

If we meet with you or other family members in the course of your child’s treatment, we will make notes of that meeting in your child’s treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child’s treatment record.

Mandatory Disclosures of Treatment Information

In some situations, we are required by law or by the guidelines of my profession to disclose information, whether or not we have your or your child’s permission. We have listed some of these situations below.

Confidentiality cannot be maintained when:

* Child patients tell us they plan to cause serious harm or death to themselves, and we believe they have the intent and ability to carry out this threat in the very near future. We must take steps to inform a parent or guardian or others of what the child has told us and how serious we believe this threat to be and to try to prevent the occurrence of such harm.
* Child patients tell us they plan to cause serious harm or death to someone else, and we believe they have the intent and ability to carry out this threat in the very near future. In this situation, we must inform a parent or guardian or others, and we may be required to inform the person who is the target of the threatened harm [and the police].
* Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, we will need to use professional judgment to decide whether a parent or guardian should be informed.
* Child patients tell us, or we otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, we may be required by law to report the alleged abuse to the appropriate state child-protective agency.
* We are ordered by a court to disclose information.

Disclosure of Minor’s Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a “zone of privacy” where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is our policy to provide you with general information about your child’s treatment, but NOT to share specific information your child has disclosed to me without your child’s agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child’s risk-taking behavior becomes more serious, then we will need to use professional judgment to decide whether your child is in serious and immediate danger of harm. If we feel that your child is in such danger, we will communicate this information to you.

Even when we have agreed to keep your child’s treatment information confidential from you, we may believe that it is important for you to know about a particular situation that is going on in your child’s life. In these situations, we will encourage your child to tell you, and we will help your child find the best way to do so. Also, when meeting with you, we may sometimes describe your child’s problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor’s Treatment Records to Parents

Although the laws of IL may give parents the right to see any written records kept about your child’s treatment, by signing this agreement, you are agreeing that your child or teen should have a “zone of privacy” in their meetings with us, and you agree not to request access to your child’s written treatment records, unless there are extenuating circumstances.

Parent/Guardian Agreement Not to Use Minor’s Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although our responsibility to your child may require my helping to address conflicts between the child’s parents, our role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena our records or ask us to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing any opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring testimony, even though we will not do so unless legally compelled. If we are required to testify, we are ethically bound not to give opinions about either parent’s custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, we will provide information as needed, if appropriate releases are signed or a court order is provided, but we will not make any recommendation about the final decision(s). Furthermore, if we are required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for our participation agrees to reimburse the office at the rate of $160 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Child/AdolescentPatient:

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor’s Signature\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child’s privacy:

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child’s/adolescent’s treatment. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist’s professional judgment, unless otherwise noted above.