SPECTRUMS FAMILY SERVICES

Treatment Consent for My Child

I do hereby seek treatment for my child, _____, date of birth: _____.
I do consent to take part in treatment provided by Spectrums Family Services, as requested. I understand that developing a treatment plan with this therapist on behalf of my child and regularly reviewing my child's progress are an essential part of therapy.

RISKS ASSOCIATED WITH PSYCHOTHERAPY: Like many things in life, psychotherapy has inherent risks. Some of these risks to your child are: Disruptions in daily life that can occur because of therapeutic changes; emotional pain due to exploring personal issues and family history; possible disruption of current relationships. Sometimes challenging behaviors get worse before they get better because new boundaries are being set. Although therapy begins with the hope that your child's life will improve, there is no guarantee that this will occur. I understand that no promises have been made to me regarding the results of treatment.

CONFIDENTIALITY: I understand that state and law professional ethics require therapists to maintain confidentiality except for the following situations:

- If there is suspected child abuse, elder abuse, or dependent adult abuse
- A situation in which a serious threat to a reasonably well-identified victim is communicated to the therapist
- When a threat to injure or kill oneself if communicated to the therapist
- If I am required to sign a release of confidential information by my medical insurance
- If I am required to sign a release for record if I am involved in litigation or other matters with private/public agencies.

I acknowledge that <u>all</u> electronic communication compromises my child's confidentiality. This includes email, texts, etc. If I choose to break confidentiality in any way (such as telling anyone about therapy), Spectrums Family Services cannot control or be held liable for the outcome.

FEES: With your permission, we will file claims for services with your insurance company. If you are paying out-of-pocket, we will provide a "good faith estimate" for services. For the initial intake appointment, the fee is $250. For subsequent 60-minute session, the fee is $215. For a 45-minutes session, the fee is $165. For a 30-minute session, the fee is $130. **I know that I must call to cancel an appointment at least 24 hours before the time of the appointment, or I may be charged $50. I agree that I am responsible for paying the fees of service my insurance company does not cover.** I understand there is a returned-check fee of $35. I further understand if I do not pay for the services received, the therapist may stop treatment. I agree I will be responsible for all attorneys and collections fees, should small claims court become involved.

END OF TREATMENT: Ideally therapy ends when agreed upon treatment goals have been achieved. However, I am aware that I may stop treatment on behalf of my child at any time. I am also aware that my therapist may discontinue therapy with my child for ethical or legal reasons. I will be responsible for paying for the services already received.

I understand that I may revoke this consent in writing any time except to the extent that action based on it has already begun and except for my financial responsibility.

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

_____ _____
Signature of client (if over 14) Date

_____ _____
Signature of caregiver Date

_____ _____
Signature of caregiver Date