

Palo Alto Parenting Solutions kk
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Office Policies and Consent for Treatment - Children

This Agreement has been created for the purpose of outlining the terms and conditions of services to be provided by **Alice Locke Chezar** (Therapist), for the minor child(ren) and is intended to provide [*name of parent(s)/legal guardian(s)*] with important information regarding my practices, policies and procedures of and to clarify the terms of the professional therapeutic relationship between Therapist and client. I will be happy to discuss any questions or concerns regarding the contents of this agreement with you prior to your signing it.

POLICY REGARDING CONSENT FOR TREATMENT OF A MINOR CHILD I generally require the consent of **both parents** prior to providing any services to a minor child. If any question exists regarding your authority to give consent for psychotherapy, I will require that you submit supporting legal documentation, such as a custody order, prior to the commencement of services.

THE THERAPY PROCESS

A minor patient will benefit most from psychotherapy when his/her parents; guardians or other caregivers are supportive of the therapeutic process.

Psychotherapy is a process in which the minor child and I, and sometimes other family members, discuss many issues, events, experiences and memories for the purpose of creating positive change so that the child can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties the minor may be experiencing. Psychotherapy is a joint effort between client and therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. Such benefits may also require substantial effort on the part of the client, as well as his/her caregivers and/or family members, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. This discomfort may also extend to other family members, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which I will challenge the perceptions and assumptions of the minor and offer a different perspective, way of looking at, thinking about, or handling situations, which can cause you to feel upset or disappointed.

During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but

may also be slow and frustrating. Please address any concerns you have regarding your progress in therapy with me.

My commitment and goal is to keep you safe from harm, to help you attain your goals, and to be present to witness your growth. In this regard, together we will establish a treatment plan and evaluate your progress on a regular basis. I will also provide you where necessary, with community resources, and refer you to support groups or other professionals when appropriate.

CONFIDENTIALITY

My first priority during our sessions is to create a safe and trusting environment for you to discuss and explore your personal concerns. All information disclosed within sessions as well as the written records pertaining to those sessions **are confidential** and may not be revealed to anyone without **your** written permission, except where disclosure is required by law.

Some of the exceptions to confidentiality include, but are not limited to the following:

- When there is reasonable suspicion of child, dependent, or elder abuse or neglect, I am mandated by law to report these instances to the appropriate agencies.
- When a client makes a serious threat of violence towards a reasonably identifiable victim, or when a client is dangerous to him/herself or the person or property of another.
- In couple and family therapy, or when different family members are seen individually, I will not release records to any outside party unless I am authorized to do so by **all** adult family members who were part of the treatment.

You should be aware that I am not a conduit of information from the minor. Psychotherapy can only be effective if there is a trusting confidential relationship between Therapist and client. Although you can expect to be kept up to date as to the minor's progress in therapy, you will typically not be privy to detailed discussions between me and the minor. However, you can expect to be informed in the event of any serious concerns I might have regarding the safety or well-being of the minor, including suicidality.

PSYCHOTHERAPIST-PATIENT PRIVILEGE

The information disclosed by you, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between the minor and I (therapist and client) in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the client is the holder of the psychotherapist-patient privilege. If I received a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-patient privilege on the minor's behalf.

When a client is a minor child, the holder of the psychotherapist-patient privilege is either the minor, a court appointed guardian, or the minor's counsel. Parents typically do not have the authority to waive the psychotherapist-patient privilege for their minor children, unless given such authority by a court of law. You are encouraged to discuss any concerns regarding the psychotherapist-patient privilege with your attorney.

You should be aware that you might be waiving the psychotherapist-patient privilege if you make the minor's mental or emotional state an issue in a legal proceeding. You should address any concerns you might have regarding the psychotherapist-patient privilege with your attorney.

IMPORTANT: RE: PATIENT LITIGATION

Special circumstance regarding parents involved in child litigation. When a child of separating/divorced parents (who are involved in litigation) bring their child for treatment, a special risk situation exists regarding the child's therapy. Specifically, if the therapist is brought into the litigation, the therapy may be seriously compromised. Therapists are generally and strongly advised by our professional boards and organizations to keep the therapy role clear and separate from the forensic/legal role. Effective child therapy is usually best accomplished when both parents have an effective working relationship with the child's therapist. It is usually in the best interests of the child's treatment for the therapist to attempt to develop a working relationship with each parent, particularly if both parents are actively involved in the life of the child or youth. Information that the therapist is asked to provide to the court is often likely to benefit one parent at the expense of the other. This is likely to compromise trust and impede an effective working relationship between the therapist and the parent whose position may have been weakened by this information.

ACCORDINGLY, WHEN PARENTS OR LEGAL GUARDIANS ARE INVOLVED IN POSSIBLE CHILD LITIGATION, I REQUIRE THAT BOTH PARTIES AGREE TO THE FOLLOWING CONDITION BEFORE BEGINNING TREATMENT (YOUR SIGNATURE AT THE END OF THIS DOCUMENT INDICATES YOUR AGREEMENT): that the purpose of the therapy is to provide individual/family services that serve the best interests of the child or youth. We recognize that the overall treatment of the child or youth may be compromised if information revealed during therapy is brought into court in the process of litigation. Accordingly, as parent/legal guardian I agree that I will not involve the therapist, Alice Locke Chezar, MFT, ATR, in any way in this litigation without Ms. Locke-Chezar's express consent. I respect the right of the therapist to make the determination as to whether any communication of information with the court or attorneys

STATEMENT REGARDING PARENTS/GUARDIANS INVOLVED IN POSSIBLE CHILD LITIGATION

"We recognize, will not, therefore, involve the therapist in any form of child custody-related litigation against his/her recommendation or will. If the services of a mental health professional are considered desirable for purposes of litigation or legal investigation or custody evaluation, the services of a separate professional or agency, other than the child's therapist (Ms. Alice Locke Chezar, MFT, ATR, will be sought."

RECORDS AND RECORD KEEPING

I may take notes during session, and will also produce other notes and records regarding your treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Such records are my sole property. I will not alter my normal record keeping process at the request of any client. Should you request a copy of my records, such a request must be made in writing. I reserve the right, under California law, to provide you with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider.

I will maintain the minor's records for ten years following termination of therapy, or when minor is 21 years of age, whichever is longer. However, after ten years, the minor's records will be destroyed in a manner that preserves his/her and your confidentiality.

PROFESSIONAL CONSULTATION

Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any of your personally identifying information.

CONFIDENTIALITY OF COMMUNICATION If you elect to communicate with me by **email** at some point in our work together, please be aware that *email is not completely confidential*, and thus privacy and confidentiality of such communication is compromised. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record. Faxes can easily be sent erroneously to the wrong address. Please notify me if you decide to avoid or limit in any way the use of any or all of the above mentioned means of communication. ***Please do not use e-mail or faxes for emergencies.***

SCHEDULING AND CANCELLATION OF APPOINTMENTS

When we schedule an appointment I make the commitment to you that I will be in my office ready to see you at that time. If you need to cancel an appointment, your cancellation notice should be left on my voicemail at **650.339.5101**. ***I request a minimum of 24 hours notice should you need to cancel.***

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for **50 (fifty) minutes**.

If you are late, your session may be shortened; we will end on time and not run over into the next person's session. You will still be required to pay for the full session.

If you have not called and are late to a therapy session, I will wait for up to **20 minutes**, and then assume that you are not coming. The regular fee will be expected for the time I reserved for you. If an emergency occurs that causes this, we can discuss the exception. If you miss a session without canceling, or cancel with less than **24 hours** notice, you will be asked to pay for that session. The confidential voicemail system has a time and date stamp which will keep track of time to cancellation.

I will make every effort to reschedule a suitable time for you to maintain the consistency of our sessions and your treatment. It is important that you give me as much notice as possible so that I can offer it to others who might need it.

In the event of an emergency, or other extenuating circumstance please call my cellphone or voicemail to let me know that you will be unable to keep our appointment. In these cases the 24-hour cancellation policy will not apply. My confidential voicemail at my office number, as well as my cellphone is active 24 hours a day.

TELEPHONE & EMERGENCY PROCEDURES

My office is equipped with a confidential voicemail system that allows you to leave a message at any time. I will make every effort to return calls as soon as possible, at the very least within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. To ease the process of returning calls, please always leave your phone number and good times to reach you directly. I will tell you well in advance of any absences, and give you the name and phone number of the therapist who will be covering my practice during my absence. I am available for brief between-session phone calls during normal business hours.

In the event that the minor or you are feeling unsafe or require immediate medical or psychiatric assistance, please do one or all of the following:

- Call **911** and proceed to your nearest hospital emergency centre
- Call Santa Clara County's Crisis Services (North County): 650.494.8420
- Call Santa Clara County's Crisis Services (South County): 408.838.2482

• **Santa Clara County's Suicide & Crisis Services:**

All Santa Clara County: 408.279.3312
(North County): Toll Free: 650.494.8420
(South County): Toll Free: 408.683.2482

• **San Mateo Crisis & Suicide Intervention Services:** <http://crisiscenter.cc/> Crisis Line: 650.579.0350 Parent Support Line: 888.220.7575 Drug & Alcohol Help line: 650.573.3950 For teens: www.onyourmind.net

• **National Suicide Prevention Lifeline:** Toll Free 24-hour: 1-800-273-TALK

INSURANCE -- Out of Network Reimbursement

I am not contracted with any insurance provider. If you request, I can provide you with a Super Bill that you can submit to your insurance company for reimbursement. This statement will include your diagnosis, the procedure code, the number of sessions, and any amount you have paid me. It remains your responsibility to contact your insurance company to determine if they will reimburse you under these terms, and if so, what percentage of the fee they will cover. Please know that your use of insurance can severely jeopardize the confidentiality of your treatment.

Please sign the following, if using your Employee Assistance Program

"I authorize the release of any information (including treatment summaries and diagnosis) necessary to process insurance or Employee Assistance claims, or to request additional sessions. (Note, client confidentiality remains the same as stated above.)

Sign here: _____

If Applicable, second client sign here: _____

The fee for my service is **\$150.00 per 50-minute session**. Sessions longer than 50-minutes are charged for the additional time pro rata.

I reserve the right to periodically adjust this fee. If a fee raise is approaching I will remind you of this well in advance. Our agreed upon fee is **\$150.00**.

Site visits, report writing and reading, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise.

Payment of fees is expected at time of your session unless prior arrangements have been made. I usually collect the fee at the beginning of the session. I recommend that you prepare your check ahead of time, so that we can make the most of our time together. Should any financial difficulties arise, please let me know so that we can deal with the situation. I accept cash, and checks,

If checks are returned for insufficient funds there is a \$20 processing fee. I am not willing to have clients run a bill with me nor do I accept barter for therapy. Any overdue bills will be charged 1.5% per month interest. If you eventually refuse to pay your debt, or it has been more than 120 days without payment of your account, I reserve the right to seek legal recourse and recoup any unpaid balance. In pursuing these measures, I will only disclose biographical information and the amount owed in order to ensure confidentiality.

TERMINATION OF THERAPY

I reserve the right to terminate therapy at my discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, client needs are outside my scope of competence or practice, or if you are not making adequate progress in therapy.

You as my client also have the right to terminate therapy at your discretion. Upon either party's decision to terminate therapy, I will generally recommend that you participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. I will also attempt to ensure a smooth transition to another therapist by offering you referrals.

DUAL RELATIONSHIPS

I do not have social or sexual relationships with clients or former clients because that would not only be unethical and illegal, it would be an abuse of the power I have as a therapist, or could impair my objectivity, clinical judgment and therapeutic effectiveness.

CONSENT TO PSYCHOTHERAPY

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I consent to the use of a diagnosis in billing, and to release of that information and other necessary to complete the billing process.

I agree to pay the fee of **\$150.00 per session**.

I understand my rights and responsibilities as a client/parent/guardian, and my therapist's responsibilities to me.

I agree to undertake therapy with Alice Locke Chezar, M.A., MFT, ATR, I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Alice Locke Chezar.

I agree to hold the therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Minor Clients Name: _____ **Date:** _____

Parents (or Guardian) Signature: _____ **Date:** _____

Name of Financial Responsible Party: _____ **Date:** _____

(if different from signature above)