



Stacey Neil, MA, LMFT  
Marriage Family Therapist Lic. #51986  
1-408-827-5139  
www.staceyneil.com

## AGREEMENT FOR SERVICE / INFORMED CONSENT FOR MINORS

### **Introduction**

This Agreement has been created for the purpose of outlining the terms and conditions of services to be provided by Stacey Neil, MA, LMFT for the minor children \_\_\_\_\_ (herein "Client") and \_\_\_\_\_ (herein "Representative(s)") with important information regarding the practices, policies and procedures of Stacey Neil, MA, 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**

Therapist generally requires 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, Therapist will require that Representative submit supporting legal documentation, such as a custody order, prior to the commencement of services.

### **Risks and Benefits of Therapy**

A minor Client 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 Therapist and Client, and sometimes other family members, discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Client 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 Client 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 to Client, 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 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 Therapist will challenge the perceptions and assumptions of the Client or other family members, and offer different perspectives. The issues presented by Client may result in unintended outcomes, including changes in personal relationships.

During the therapeutic process, many Clients 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. Client should address any concerns he/she has regarding his/her progress in therapy with Therapist.

### **Telehealth Services**

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and my therapist may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.
6. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is

effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

7. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.
8. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

### **Professional Consultation**

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Client or Client's family members or caregivers.

### **Records and Record Keeping**

Therapist may take notes during session, and will also produce other notes and records regarding Client's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any Client or representative. Should Client or Representative request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Client, or Representative, with a treatment summary in lieu of records. Therapist also reserves 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. Representative will generally have the right to access the records regarding Client. However, this right is subject to certain exceptions set forth in California law. Should Representative request access to Therapist's records, such a request will be responded to in accordance with California law.

Therapist will maintain Client's records for ten years following termination of therapy, or when Client is 21 years of age, whichever is longer. However, after ten years, Client's records will be destroyed in a manner that preserves Client's confidentiality.

### **Confidentiality**

The information disclosed by Client is generally confidential and will not be released to any third party without written authorization from Client, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, 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.

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

### **Client Litigation**

Therapist will not voluntarily participate in any litigation, or custody dispute in which Client and another individual, or entity, are parties. Therapist has a policy of not communicating with Client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Client's legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Client, Client agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary hourly rate of \$200. In addition, Therapist will not make any recommendation as to custody or visitation regarding Client. Therapist will make efforts to be uninvolved in any custody dispute between Client's parents.

### **Psychotherapist-Client Privilege**

The information disclosed by Client, as well as any records created, is subject to the psychotherapist-Client privilege. The psychotherapist-Client privilege results from the special relationship between Therapist and Client in the eyes of the law. It is akin to the attorney-client privilege or the doctor-Client privilege. Typically, the Client is the holder of the psychotherapist-Client privilege. If Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-Client privilege on Client's behalf until instructed, in writing, to do otherwise by a person with the authority to waive the privilege on Client's behalf. When a Client is a minor child, the holder of the psychotherapist-Client privilege is either the minor, a court appointed guardian, or minor's counsel. Parents typically do not have the authority to waive the psychotherapist-Client privilege for their minor children, unless given such authority by a court of law. Representative is encouraged to discuss any concerns regarding the psychotherapist-Client privilege with his/her attorney.

Client, or Representative, should be aware that he/she might be waiving the psychotherapist-Client privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Client, or Representative, should address any concerns he/she might have regarding the psychotherapist-Client privilege with his/her attorney.

### **Fee and Fee Arrangements**

The usual and customary fee for service is \$200 per 50-minute session. Sessions longer than 50-minutes are charged for the additional time pro rata (\$4/min). Therapist reserves the right to periodically adjust this fee. Representative will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, HMOs, managed care organizations, or other third-party payers, or by

agreement with Therapist.

The agreed upon fee between Therapist and Representative is \$200. Therapist reserves the right to periodically adjust fee. Representative will be notified of any fee adjustment in advance.

From time-to-time, Therapist may engage in telephone contact with Client or Representative for purposes other than scheduling sessions. Representative is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at the request of Client or Representative and with the advance written authorization of Client or Representative. Representative is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes.

Representative is expected to pay for services at the time services are rendered. Therapist accepts cash, checks, and major credit cards, including Visa, Master Card, American Express, and Discover.

### **Insurance**

Representative is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payer. Representative is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles.

Therapist is not a contracted provider with any insurance company, managed care organization. Should Representative choose to use his/her insurance, Therapist will provide Representative with a statement, which Representative can submit to the third-party of his/her choice to seek reimbursement of fees already paid.

### **Cancellation Policy**

Representative is responsible for payment of the agreed upon fee for any missed session(s). Representative is also responsible for payment of the agreed upon fee for any session(s) for which Representative failed to give Therapist at least 24 hours notice of cancellation. Client will fill out an automatic authorization form for payment in case of an appointment not cancelled outside of 24 hours. Cancellation notice should be left on Therapist's voice mail at 1-408-827-5139.

### **Therapist Availability**

Therapist's office is equipped with a confidential voice mail system that allows Client or Representative to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Client is feeling unsafe or requires immediate medical or psychiatric assistance, Client or Representative should call 911, or call the 24-hour Suicide and Crisis Service toll free at 855-278-4204, or go to the nearest emergency room.

**Termination of Therapy**

Therapist reserves the right to terminate therapy at his/her 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 of Therapist’s scope of competence or practice, or Client is not making adequate progress in therapy. Client or Representative has the right to terminate therapy at his/her discretion. Upon either party’s decision to terminate therapy, Therapist will generally recommend that Client 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. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Client or Representative.

**Acknowledgement**

By signing below, Representative acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Representative has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Representative’s satisfaction. Representative agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Representative agrees to hold 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.

\_\_\_\_\_

\_\_\_\_\_  
Client Name (please print)

\_\_\_\_\_  
Signature of Client (if Client is 12 or older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Representative (and relationship to client)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Representative (and relationship to Client)

\_\_\_\_\_  
Date

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payer.

\_\_\_\_\_  
Name of Responsible Party (Please print)

\_\_\_\_\_  
Signature of Responsible Party (and relationship to Client)

\_\_\_\_\_  
Date