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Treatment Agreement for Child/Adolescent Therapy

This document is intended to provide important information regarding your treatment. Please read the entire document carefully and be sure to ask any questions that you may have regarding its contents.

About Child/Adolescent Counseling

Child/adolescent therapy seeks to involve the entire family system in the process of change and healing. A child's world and well-being is greatly affected by those nearest to him/her. Parents, siblings and other family members may be asked to attend either individual or joint sessions for a variety of reasons. These sessions can assist with exchanging information, finding solutions to specific problems that have arisen, improving communication skills and exploring how the family system may be contributing to the child's struggles.

In my work with children and families I focus on treatment issues. I do not involve myself in legal issues, including but not limited to writing letters to the court or providing custody evaluations. If you are seeking a therapist for these purposes please let me know and I can provide you with an appropriate referral.

Appointments

Appointments are 45 minutes long and occur weekly unless otherwise agreed. It is strongly recommended that appointments occur on a weekly basis for the greatest benefit. The first two or three appointments are for assessment and you can expect them to be different from a "normal" session. Their purpose is to gather information and to evaluate if and how I can be of assistance. This is also a time for you to assess whether this is a good therapeutic match for you. I encourage you to discuss with me any concerns that you might have. Appropriate referrals will be given to you if either you or I determine that your therapeutic needs would be better met elsewhere.

Fees

The fee for each 50 minute session is \$_____. If EMDR (Eye Movement and Desensitization and Reprocessing) is included as part of your treatment, EMDR sessions may be scheduled for a session and a half (75 minutes); the fee for an extended EMDR session is \$_____. Payment is due at the time of the appointment. Cash or personal checks are accepted.

KATE WARWICK-SMITH, MA, MFT

Insurance

If you are utilizing health insurance benefits to pay for my services, please be advised that the amount of reimbursement, co-payments or deductible will be specific to your insurance plan. Insurance plans generally limit coverage to certain diagnosable mental conditions. So, you should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. While I may submit insurance claims for you, you are still responsible for any portion of the fee not paid by your insurance plan. Co-payments are due at the time of the session.

Canceling Appointments

If you wish to cancel an appointment please give 24 hours notice or you will be charged for the missed appointment. Insurance companies will not pay for missed or cancelled sessions; understand that payment for those session will be your responsibility. You will be charged \$_____ for missed sessions (no shows) or those cancelled without 24-hour notice.

Minors and Confidentiality

What takes place between a therapist and minor client is confidential and shall not be disclosed to others except when required by law or with a legal guardian’s express written consent. However, parents and guardians who provide authorization for their child’s treatment are often involved in their treatment. Consequently, in the exercise of my professional judgment, I may discuss the treatment of a minor patient with parents or caretakers. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with me.

Breaking therapeutic confidentiality is mandated by law when I have reason to believe that an incidence of child or elder abuse/neglect has occurred, if there is a threat of serious harm to one’s self or others, or if a court order has been issued. In addition, a federal law known as The Patriot Act of 2001 requires therapists in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act. Other exceptions may be outlined in my *Notice of Privacy Practices*.

Please sign the following, if using insurance or employee assistance program benefits:

I, _____(Name of Parent/Guardian), authorize the release of any information for _____ (Name of Minor Client) including treatment summaries and diagnosis necessary to process insurance or Employee Assistance claims, or to request additional sessions. I authorize payment of benefits to be made to Kate Warwick-Smith, MFT for services provided.

Signature

Printed Name

Date

No-Secrets Policy

In family therapy, sometimes one individual divulges to the therapist a secret they do not want to be told to other individuals of the conjoint therapy. If this should occur I will encourage and support efforts to share this information with the other participants. I do not hold secrets. If you have any questions about this please do not hesitate to ask. The following is intended to further clarify this policy:

This written policy is intended to inform you, the participants in family therapy that when I agree to work with a family, I consider that family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (the treatment unit).

During the course of my work with a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions are a part of the work that I am doing with the family. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. Since these sessions are considered a part of the family therapy, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

There may be times, however, when I may need to share information learned in an individual session (or a session with only a portion of the treatment unit) with the entire treatment unit — that is, the family, if I am to effectively pursue the treatment of the family. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to treat the family unit by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family during their therapy, I might be placed in a situation where I will have to terminate treatment of the family. This policy is intended to prevent the need for such a termination.

KATE WARWICK-SMITH, MA, MFT

Therapist Availability / Emergencies

Telephone consultations between office visits are welcome. However, I will attempt to keep those contacts brief as important issues are better addressed within regularly scheduled sessions. If a conversation looks like it will extend longer than 15 minutes, I will ask if you would like to schedule an appointment to continue the discussion.

You may leave a message for me at any time on my confidential voicemail. If you would like for me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours. If you have an urgent need, please indicate that fact in your message and follow any instructions that are provided on my voicemail. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Ending Therapy

You have the right to end therapy at any time. However, I ask that you agree to attend one final session before terminating. At times therapy can be uncomfortable stirring up feelings that may be difficult to hold or express and cause you to think about ending therapy. I encourage you to discuss these feelings in order to fully explore the issues involved and take advantage of what might be an important healing juncture.

Privacy Policy

By signing this form, you acknowledge receipt of my *Notice of Privacy Practices*. This *Notice* provides information about how I may use and disclose your protected health information. I encourage you to read it in full. My *Notice of Privacy Practices* is subject to change; if changed, I will give you a revised *Notice*. If you have left treatment, you may obtain the revised notice from me at the above address or from my website at:
<http://www.katews.com>.

If you have any questions about any of the above, please feel free to ask.

Client Name (please print): _____
Signature: _____ Date: _____

Client Name (please print): _____
Signature: _____ Date: _____

Client Name (please print): _____
Signature: _____ Date: _____

Client Name (please print): _____
Signature: _____ Date: _____