INFORMED CONSENT (MINOR)

Confidentiality

The material that clients disclose is confidential and cannot be released without their written consent. There are certain circumstances, however; under which I may be legally required to disclose information without consent of the client. These include:

1. If there is a reasonable belief or suspicion that child abuse has occurred
2. If there is a reasonable belief or suspicion that elder or dependent adult abuse has occurred
3. If the client makes a threat to harm another person
4. If the client poses a risk to him/her self, or others
5. If the client enters into a legal proceeding in which they raise the issue of their mental status, then the court may order the clients records

Confidentiality in Family Therapy

Family therapy may include both joint and individual sessions. In such circumstances the family hereby agrees to waive their right to confidentiality so that information shared in individual sessions can be shared in joint sessions at the discretion of therapist. To maintain an atmosphere of openness and honesty, my policy is that I am unwilling to collude with secrets, wherein one family member shares information with me that they wish to keep from other family members. Some information can be kept confidential, but it will be at the discretion of therapist (excluding any of the exceptions listen in the "Confidentiality" section above). Any phone call or electronic communication made by a family member to the counselor may be discussed in joint session to maintain openness and trust.

Parent Consultation

Parents, as mentioned above, are entitled to some information, such as if the child is in danger or knows someone else who is in danger. These topics will not be kept secret from the parents. However, therapy with teenagers works best when they know I will keep non-pertinent information confidential. You as a parent may have updates about treatment planning (i.e. topics of what we are working on in treatment) but no details or conversations will be shared without the client's permission.

Record Keeping

I will keep notes of my impressions of the client's work in counseling. The details will be limited, but enough for me to review progress and track developments in my work with the client. These records will be stored in a locked file inside the office building and can be subpoenaed by a judge or through court of law.

Termination

Termination typically occurs once goals are met and client feels as though they are no longer in need of therapeutic services. However, I do not work with clients that I determine are unwilling to get help or I think would not benefit from my services. In this case, I would discuss the matter with the client and I would provide referrals that may be a better fit.

Risks and Benefits of Therapy

A minor client will benefit most from psychotherapy when his/her parents, guardians or other caregivers are supportive of therapeutic process. Participating in therapy may result in a number of benefits to the 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 the client, as well as his/her caregivers and/or family members. 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, and the process may evoke strong feelings. The issues presented by the client may result in unintended outcomes, including changes in personal relationships. During therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. The client should address any concerns he/she has regarding his/her progress in therapy with me as therapist.

Telehealth

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. You have a right to confidentiality with regard to treatment and related communications via Telehealth under the same laws that protect the confidentiality of treatment information during in-person psychotherapy. There are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of the therapist, that your psychotherapy sessions and transmission of treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of treatment information could be accessed by unauthorized persons. There is a risk of being overheard by persons near the client and the client is responsible for using a location that is private and free from distractions or intrusions.

COVID-19

At this time, California Association of Marriage and Family Therapists (CAMFT) recommends that therapists see patients via Telehealth unless the patient is not clinically appropriate for Telehealth services. Sessions will remain through Telehealth until it is safe to return to the office, which will be determined by the comfort level of the therapist, as well as CAMFT and other state regulating boards. If, for any reason, sessions resume in person, the expectation would be that both therapist and client wear a facial covering the entire session sanitize hands before and after entering the office, maintain social distance, sanitize surfaces touched, and that the client of therapist would stay at home if any symptoms of sickness were experienced in which case, Telehealth would be offered as an alternative.

THERAPIST POLICIES

Appointments/Cancellations
A standard appointment time is 50 minutes in length. The appointment time is reserved for each person specifically. It is the client's responsibility to notify me at least 24 hours in advance if they are unable to attend. If the client does not cancel more than 24 hours in advance, or does not show up for the appointment, the parent/guardian will be expected to pay in full for the missed session within 24 hours.

Contacting the Therapist (non emergency)
I can be reached by confidential voicemail by dialing 707.720.3400. I am not always available to answer the phone, but will check the voicemail periodically. If the client leaves a voice message, I will return the phone call, but it may take up to 48 hours if it is not an emergency.

Parent Communication
Parents are welcome to inquire about their child's care at any time. I will give updates as requested, which include details about the therapeutic treatment plan, but never details of what was shared in session—unless relating to client safety. I do not share conversational details, or any other details that do not pertain to client safety. For counseling to work, your teen must know what they say will not be repeated.

Emergency Calls
It is important to seek help immediately by going to a hospital or dialing 911 in any life-threatening emergency. Please follow this plan FIRST, and then call me after, if emergent:

1. Contact Mental Health Crisis Services at 707.253.4711
2. Go to your local hospital emergency room
3. Call 911 and speak to a mental health worker on call

Email/Phone Communications
I am happy to counsel over the phone from time to time as needed by the client, but am not willing to counsel via text. Text message may be utilized to discuss payment or scheduling concerns. One potential risk, however, is that client privacy cannot be guaranteed via email or texting. Please use discretion when sending personal information in an email or over text message.

Professional Consultation
From time to time, to best serve you or your child as a client, it is best practice and standard of care in the MFT profession to consult with colleagues. In these circumstances, name and identifying information is not disclosed.

Social Media
As a general rule I do not allow clients to follow me on social media, and I do not follow clients on social media. This can potentially put client confidentiality at risk, as well as skew objectivity.

STATEMENT OF ACKNOWLEGEMENT

General Consent To Counseling: By signing this form, I consent on behalf of my minor child to counseling with Mary Elizabeth “Emmy” Clausen, LMFT119269.

A signature on this form serves as your acknowledgement that you have read and understand both the Informed Consent and Therapist Policies and agree to their terms:

Printed First and Last Name of Client

_____

Signature of Client (if over 12 years old)

_____ Date _____

Signature of Parent/Guardian (if client is under 18 years old)

_____ Date _____

Signature of Counselor

_____ Date _____

FEE AGREEMENT

Payment:

- *Individual counseling*: The fee for this service is $140.00 per 50-minute session.
- *EMDR*: The fee for this service is $150.00 per session.
- *Telephone conversations*: Phone conversations are sometimes necessary and do not incur a charge if they are less than 15 minutes. However, for every phone call that goes over 15 minutes, the client will be charged the price of a session, or $140.00. If more than a 15-minute phone call is needed, I recommend that the client schedule a session.

Payment is accepted in the form of cash, check, or credit card at the time the service is rendered, and most commonly the IVY Pay app is utilized for payment rendering. The fee for bounced checks is $35.00. Insurance is not accepted, however, I am willing to issue you a Superbill for you to submit to insurance after services are rendered and paid for in full. One thing to note about the Superbill, is that it must include a DSM-V Diagnosis, which will be discussed with you if requested. Clients are not permitted to carry a balance. If payment is missed, the responsible party will be expected to pay the balance before the client’s next session. By signing this consent, you agree to pay the above amount in full for service at time it is provided. If the fee amount poses an undue hardship, please discuss this with your therapist.

I have read and understand the above statements.

Parent/Guardian Signature: _____ Date: _____

CHILD (ADOLESCENT) INTAKE FORM

Today's Date:_____ Referred by: _____

Child's Full Name:_____

Nickname: _____ Birth Date: _____

Please provide the following information about the client child's family:

Parent/Guardian

Names:_____

Address:_____

Phone:_____ Email:_____

The name of the child's biological parents (if different from above):

Mother: _____

Father: _____

Parent's Marital Status (circle one):
Single Married Widowed Separated Divorced

Who has legal guardianship of the client child?

_____

Please describe any past counseling that either your child or any other family member has had. Was it helpful? Explain:

Does anyone in the child's family currently use (or in the past) any type of drug, tobacco or alcohol? _____ *If yes, please describe:*

Please provide the following information about your child:

Do you have any other concerns about your child or your family that you have not mentioned yet?

Treatment Goals:
What problem behaviors do you want to see change FIRST and how much must they change in order for you to be satisfied?

Education History:

What school does your child attend? _____

Current grade? _____

Has your child ever received any special education services?

Has your child experienced any of the following problems at school?

fighting	lack of friends	drug/alcohol
detention	suspension	learning disabilities
poor grades	poor attendance	bullying
behavior problems	incomplete homework	

What does your child's teacher say about him/her?

Medical History:

Date of your child's last medical examination: _____

Please list any current medical conditions and/or medications for your child:

Other History:

Has your child ever experienced any type of abuse (physical, sexual, or verbal)? If so, please describe:

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else?

Has he/she ever purposely hurt him/her self or another? If yes to either question, please describe the situation:

Has your child ever experienced any serious emotional losses (such as the death of or extended physical separation from a parent or other caretaker)? If yes, please explain:

YOU HAVE COMPLETED THE INTAKE PACKET! THANK YOU AND I LOOK FORWARD TO GETTING TO KNOW YOU AND YOUR CHILD BETTER!