D A V I D M I C H A L I C E K, M. A.
Licensed Marriage and Family Therapist

MINOR CHILD

CONTRACT FOR PROFESSIONAL SERVICES

Thank you for considering me for your therapeutic needs. Therapy creates a relationship that is close and personal, but also must be kept in a professional context. This document contains important information about my professional services and business policies. Please read it carefully. Note any questions you have so we can discuss them. When you sign this document it will represent a binding agreement between us.

PROCESS OF THERAPY

Your child's participation in therapy can result in a number of benefits to your child, including improved emotional adjustment and the resolution of specific concerns which led you to seek therapy for your child. However, to achieve these results, psychotherapy requires your child's very active effort, involvement, honesty, and openness. If your child is resistant or ambivalent about therapy, the process will take longer.

If your goal for your child is primarily behavioral (e.g., address temper tantrums), then in addition to or instead of therapy for your child, I will likely suggest parenting courses, couples therapy, family therapy, or other forms of support for you, the parent(s). Changing the environment the child lives in is often more effective than therapy when desiring to change a child's behavior.

You should know there are potential risks associated with therapy. It is not uncommon for symptoms to get worse before they get better. Exploration of current challenges can lead to emotional discomfort and the re-experiencing of old hurts, losses, or sad events. In addition, while at times change can come swiftly, it is important to recognize that long-standing patterns often do not change quickly and that making changes to these patterns requires dedication and effort. Due to the varying nature and severity of problems, and the uniqueness of each client, it is impossible to predict the length of therapy or to guarantee a specific outcome or result.

CONFIDENTIALITY

All information disclosed within sessions and the written records pertaining to those sessions are confidential. I will not reveal your or your child's information to anyone without your written permission, except where disclosure is required by law.

Consultation with the parent or guardian is an ongoing part of the treatment of a minor child. However, for therapy to be effective with a child, it is often necessary for children to develop a "zone of privacy" from their parents in order to feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy, and even more so for children of divorcing parents where the divorce is conflictual. Therefore, information about your child's treatment will be provided with the knowledge of the child and generally at a summary level. You can be assured that should your child be engaging in behaviors that put him/her at risk, you will be notified as soon as possible. By signing this agreement, you are acknowledging that you are aware of and agree to this need for privacy as an important part of your child's treatment.

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P H O N E : (4 0 8) 6 2 8 – 9 1 7 9

Professional consultations: Professional consultations are an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consults with appropriate professionals. During these consults, I do not reveal any personally identifying information regarding my clients.

Legal and ethical limits to confidentiality: You should be aware the law mandates a report be made where there is a reasonable suspicion of child, elder, or dependent adult abuse or neglect. I am also required to breach confidentiality where a client presents a danger to self or to others. In addition, a court of law may order the release of clinical records.

Using health insurance: If you choose to seek reimbursement from your health insurance carrier, I will provide the information required for processing your claim to you. Insurance coverage is intended for healthcare related to accidents and illnesses. Therefore, most providers require disclosure of a *mental illness diagnosis* for reimbursement. If you are concerned about the confidentiality of this information, you should contact your insurance carrier.

PAYMENTS

Fees are set at the outcome of therapy and are *payable at the beginning of each session*. Fees may be reassessed on a periodic basis. Sessions are either 50-minute (Individual) or 75-minute (Family). Any ad-hoc services (e.g., over-time sessions, e-mails, phone call consultations) will be billed on a pro-rated basis and are payable at the next session. You can make payments by check or cash (with cash, correct change is required). *It will save your valuable session time if you make checks out in advance.*

Please inform me if any problem arises during the course of therapy affecting your ability to make timely payments. For both legal and ethical reasons, I avoid getting in to a creditor-debtor relationship with my clients, and therefore I do not continue rendering services if there is a balance on a client's account. If desired, I can provide billing statements for submission to the third-party of your choice to seek reimbursement of fees already paid.

DRUG AND ALCOHOL POLICY

If a client comes to therapy under the influence of drugs or alcohol, the session will be terminated and the client will be charged the full fee.

EMERGENCY & TELEPHONE PROCEDURES:

Please feel free to leave a message at any time on my voicemail (408) 628-9179. Your call will be returned by no later than the end of the next business day. As circumstances require (e.g. upcoming stressful events), special arrangements can be made as needed for check-ins or increased availability. I will arrange for coverage by a qualified therapist if I am out of town or otherwise unavailable for an extended period of time. For ethical and legal reasons, and to protect my client's confidentiality, I do not respond to e-mails of a clinical nature.

As a solo practitioner, I am unable to provide 24-hour crisis service. In the event you are in crisis and require immediate attention, go to your nearest emergency room, call 911 (Police/ Ambulance) or 1-855-278-4204 (Santa Clara County Hotline). After contacting emergency services, leave me a detailed message on my voicemail indicating the nature of the emergency, and where and when I can best contact you. I will return your call as soon as possible.

TERMINATION:

In initial meetings, we will assess whether my services can be of benefit to your child. I do not accept clients I do not believe I can help. In such a situation, I will provide you with referrals to other therapists you can contact. If at any point during psychotherapy I assess that the treatment is not effective in helping your child reach their therapeutic goals, I am obligated to discuss it with you and, if appropriate, terminate treatment and provide appropriate referrals.

You have the right to terminate your child's therapy at any time. If you choose to do so, I will offer to provide you with names of other qualified professionals whose services you might prefer. I also reserve the right to terminate therapy at my discretion (e.g., conflicts of interest, failure to participate in therapy, untimely payment of fees).

LITIGATION LIMITATION:

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to matters that are of a confidential nature, your child should be assured of his or her privacy. In addition, therapeutic services are different from forensic and custody evaluation services, and it is generally considered unethical to combine legal/evaluative and therapeutic services. Unless otherwise agreed to in advance, this indicates that should there be legal proceedings, neither you, nor your legal representative will call on me to provide testimony or records related to your child's care. In signing this document, you acknowledge that my involvement in litigation has the potential to harm the therapeutic relationship and violate your child's need to privacy and safety in the therapeutic relationship. In the case I am legally compelled to provide records or testimony, I will provide services on a pro-rated full fee basis.

APPOINTMENTS AND CANCELLATIONS:

Since the scheduling of an appointment reserves that time specifically for you, **a minimum of 24 hours notice is required for the rescheduling or cancellation of an appointment.** You agree to pay the full fee for any sessions missed without such notification. Insurance will not pay for missed appointments. **Cancellations must be made by phone/voicemail** (Sorry, no short-notice cancellations via e-mail as these may not be timely).

I strive to see all of my clients in a timely manner. However, because my calendar is often full, if we are unable to set and keep a regular schedule, I cannot guarantee that I will be always be able to see your child in a timely manner.

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My signature below indicates I have read and understand the information in this document and agree to abide by its terms. I am the custodial parent or legal guardian of the child entering treatment and I consent to have my minor child participate in treatment.

Child's Name _____ Age: _____

Parent(s) or Legal Guardian:

Signature _____ Date _____

Signature _____ Date _____

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