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INFORMED CONSENT AND OFFICE POLICIES - CHILD/ADOLESCENT

Welcome to my practice! I am a clinical psychologist whose goal is to help children, adolescents and young adults utilize their strengths to become more competent and confident, and to support parents as they help their children grow. This document contains information about psychotherapy as well as financial and business policies that I am required to have you review before we begin. Please read it carefully and ask for any clarification. When you sign this document, it will represent an agreement between us. It will reflect your consent for your child or teen to participate in an evaluation and to allow appropriate treatment to be provided by me. You may withdraw your consent at any time by telephone, in person, or in writing.

PROFESSIONAL BACKGROUND

As a licensed psychologist, I have been trained in the diagnosis and treatment of psychological, emotional, behavioral, and interpersonal problems in children, adolescents and young adults. I have expertise working with a number of concerns including mood, anxiety, and eating disorders; gender identity and sexuality concerns; behavioral concerns; learning or academic concerns; and adjustment to life stressors, including divorce, chronic pain and other acute and/or chronic medical conditions. I earned my Ph.D. in clinical psychology from the University of Rochester in 2003 and completed a year of postdoctoral fellowship at the University of Rochester Medical Center (URMC). Following my fellowship training, I worked in the community at a not-for-profit before accepting a full-time position as a member of the research and training faculty at the URMC. I entered private practice in 2009.

PSYCHOLOGICAL SERVICES

Emotional and behavioral health treatment is not easily described in general terms. It varies depending on many factors, including the personalities of the patient and psychologist, life experiences, developmental stage and patient and/or family goals. There are different approaches that can be used. Psychotherapy requires an active effort on the patient and/or family's part as well as a working relationship among participants in which

together we identify the issue you and/or your child would like to resolve. Thus, our first few sessions will involve an evaluation of your and your child's needs. I will assess if I can be of benefit to your family. I do not accept patients who I feel I cannot help. In such a case, I will provide you with the names and numbers of other professionals that you can contact. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include. You should evaluate this information along with your own opinions of whether you and your child feel comfortable working with me. If you and your child decide to continue with therapy, we will develop treatment goals. I take a flexible approach to therapy. Specific treatment modalities will vary based on the individual needs and goals of each client and family, and may include play therapy, CBT, DBT and/or IPT. Although there is no guarantee that treatment goals will be met, I will apply my resources in good faith to help you and your child reach them. If you have questions about my procedures, we should discuss them as they arise.

Psychotherapy can have both benefits and risks. Since therapy often involves discussing difficult aspects of life, your child may experience uncomfortable feelings and changes in behaviors and thoughts. This is a normal part of the therapy process. It is important that you consider carefully whether these risks are worth the benefit of the change you are seeking. Most people who take these risks find that therapy is helpful. It often leads to a significant reduction of feelings of distress, better relationships, and resolution of specific problems.

As treatment progresses, we will reevaluate your child's treatment. Usually, we will come to a mutual understanding when your child's treatment goals have been met. You do, however, have the right to stop treatment at any time. Also, if at any point during psychotherapy, I assess that I am not effective in helping your child, I am obligated to discuss it with you and, if appropriate, to terminate treatment. If either case arises, I would attempt to give you a number of referrals that may be of help to you.

The process of termination (ending treatment) is generally one of the most important times in therapy. The length of the termination depends on many factors, including the length of treatment. I work with parents to set a termination date before it is discussed with the child. Please keep in mind that when working with children, it is especially important for treatment to end in a planned and mindful way. Therefore, I encourage all families to have at least one termination session in order to provide children with a "good goodbye."

It is important to remember that our relationship is professional rather than social. I am not allowed, because of the ethical boundaries of my profession, to advise you from professional viewpoints beyond my scope of practice (e.g., law, medicine, finance). Our contact, other than chance meetings, will be limited to appointments you arrange with me. I cannot attend social gatherings, accept gifts, or form a relationship in any other way than in the professional context of our sessions. These guidelines have been established by the profession to protect you and your child. If you and I meet in a public place, I will leave it to

you to say hello first in order to protect your confidentiality.

CONFIDENTIALITY

Your child's rights include confidentiality regarding his/her protected health information (PHI). In most situations, I can only release information about your child's treatment to others if you sign a written authorization form. However, there are some limitations of confidentiality:

- I am required by law to report suspected maltreatment, abuse, or neglect of a child to appropriate authorities.
- If I learn that a patient intends to harm him/herself or others, I may be required to break confidentiality and take protective action to ensure that everyone remains safe. Such measures may include seeking an evaluation at the psychiatric emergency department, or notifying parents or others who can help create and support a safety plan. If such situations arise, I will make every effort to fully discuss it with you before taking any action, and will limit my disclosure to what is necessary. In addition to taking protective actions, I may need to report to the local Director of Community Services. The local Director of Community Services may then disclose the patient's name and other non-clinical identifying information to the NYS Division of Criminal Justice Services (DCJS) to determine if the patient (or their guardian) has a firearms license. If the patient, parent or guardian has a firearms license, the DCJS will report that information to the local firearms licensing official, who may either suspend or revoke the license and who will use this information to make decisions about the granting of a firearms license in the subsequent five (5) years (NYS SAFE ACT MHL 9.46).
- Many insurance carriers require periodic updates about your child's progress in treatment. When I am required to share information, I will provide the minimum necessary information in order to ensure safety and proper treatment.

Confidentiality and privacy issues in the treatment of children and adolescents are very complex. I believe that in nearly all circumstances, parental involvement is essential to ensure the success of treatment. Throughout the course of our work together, I will encourage your child to share or to allow me to share with you any information that seems important for you to know or is likely to be helpful. With younger children, parents are almost always involved in each session, though I often meet individually with the child for a portion of the session. However, older children and adolescents are often reluctant to talk about their concerns unless they are confident that the details of what they discuss will not be shared with others without their permission. Violation of the trust of a child or adolescent in the therapeutic relationship can undermine their progress and make them very reluctant to

seek help or share sensitive information with health professionals in the future.

When providing treatment to children, I request an agreement between myself and the child that I can share whatever information I consider necessary with his/her parent(s). For adolescents, I request an agreement between myself, the adolescent, and their parent(s) allowing me to share general information about the progress of his/her treatment, his/her attendance at scheduled sessions (if coming alone), and any serious safety concerns. Communication regarding any other information the adolescent shares with me will require the adolescent's authorization, unless I feel he/she is in danger or is a danger to someone else, in which case I will notify the parents of my concern. Before giving parents information, I will discuss the matter with the adolescent, if at all possible. As mentioned above, I will encourage your adolescent to share with you any important information.

I recognize that agreeing to allow a child or adolescent to have such confidential communication with a professional requires a high degree of trust on the part of the parent(s). I am always happy to begin treatment by meeting with the parent(s) alone first, to discuss any concerns you may have.

It is my standard practice to seek consent for and then to obtain information from important people in the lives of the children and teens with whom I work. This almost always includes noncustodial parents, physicians, and someone who works with the child at school but may also include childcare providers and other family members. Getting information from multiple collateral sources allows me to get a better picture of the kinds of difficulties that children and teens are having. It also allows me to assure that care is coordinated between people who work with your child/teen.

Your participation, as a parent or guardian, in therapy is important, and often essential to the success of treatment. However, you are not considered to be a patient and you are not the subject of the treatment. Psychologists have certain legal and ethical responsibilities to patients, and the privacy of that relationship is given legal protection. My primary responsibility is to my patient (your child) and I must place his/her interests first. You, as a collateral, have less privacy protection.

No record or chart will be maintained on you in your role as a collateral. Notes about you may be entered into the patient's chart. The patient (or other parent/guardian) may have the right to access the chart and the material contained within it. It is sometimes possible to maintain the privacy of our communications. If that is your wish, we should discuss it before any information is communicated.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records, including written notes of all sessions. Records of any services received by me are maintained in password-protected computer files and/or in a paper file within a locked entity. Computerized records are erased approximately seven years after we end our

psychologist-patient relationship contract. Except in unusual circumstances in which disclosure would physically endanger you and/or others or makes reference to another person, you may examine and/or receive a copy of your clinical record, if you request it in writing. Alternatively, I can prepare a summary for you. NYS law requires, for children over the age of 12, their consent for anyone else to examine their records, including parents and guardians.

APPOINTMENTS

Psychotherapy appointments are usually scheduled once each week or every other week for 45-55 minutes per visit, though sometimes there are exceptions. An appointment is a commitment to our work. We agree to meet at my office and to be on time. If I am ever unable to start on time, I ask for your understanding, and I assure you that you will receive the full time agreed to if possible. If you are late, we will likely not be able to meet for the full time. I will provide advance notice of any planned absences. For short absences and clinician illness, I will attempt to reschedule your appointment as soon as possible.

A responsible adult must be present for the entire session for children under the age of 12 or who have a history of disruptive behavior. There may be times when I encourage you to make other arrangements for siblings of minor patients. Parents are often an important part of sessions and it can be difficult to divide your attention between the therapy session and supervising siblings.

CANCELLATION POLICY

When we schedule an appointment, it has been reserved just for you. Therefore, **I require a minimum of 24 hours notice for rescheduling or cancelling an appointment.** The full session fee will be charged for sessions missed without such notification. If you are more than 15 minutes late for your session, the appointment will be cancelled and you will be charged the full session fee. Missed appointments and late cancellation fees are not covered by your insurance. Additionally, if you miss a session without notifying me, all future scheduled appointments will be cancelled, and you will need to call to reschedule them. If missing appointments becomes a chronic issue, I may no longer be able to work with you. If this becomes the case, I will provide appropriate referral to other providers at your request.

PROFESSIONAL FEES

My standard fees are $195 for the initial evaluation (first two appointments) and $150 per subsequent 45-55 minute session. Actual charges may be somewhat lower based on specific contracts with your insurer. **Co-payments are due at the time of each session**. I accept checks, cash, and most credit cards. Having your check made out prior to the session allows for full use of session time. I am able to bill most insurance

companies directly for the remainder of the charge. If you are on on a deductible plan, I typically bill the insurance company first, and then bill you if you have not yet met your deductible. In most cases, if I am not an in-network provider in your insurance plan, I will accept full payment directly from you, and then provide you a bill with all required information for you to send to your insurance provider in order that you receive reimbursement directly from the insurance company. Please speak with me if you are having difficulty paying for treatment and we can arrange a payment plan. When fees are not paid for services rendered, a collection agency may be used and given appropriate billing and financial information. Should six (6) or more consecutive months lapse in your child's treatment, he/she will be considered a new patient if he/she returns to my practice, and new patient procedures/fees will apply. It is your responsibility to ensure that the contact information I have on file for you remains current.

If a payment by check results in insufficient funds a $30.00 fee will be assessed. In addition to fees for office visits, I charge $150.00 per hour for other professional services (e.g., attending meetings at your child's school). These services are not covered by health insurance, so you will be responsible for the full amount. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $250.00 per hour for preparation for, travel to and from, and attendance at any legal proceeding.

HEALTH INSURANCE

If you have health insurance, it will usually provide some coverage for mental health treatment. In some cases, I am able to bill your insurance company directly. In other cases, I cannot. However, **you, and not your insurance carrier, are responsible for full payment of my fees.** Not all services are covered in all contracts. I can assist you in verifying your insurance benefits; however, it is ultimately your responsibility to know what services are authorized and covered.

I will not bill secondary insurance policies directly. You are responsible for the secondary billing. I will provide you the necessary information for secondary billing from the primary insurance carrier.

If you choose to seek reimbursement from your health insurance carrier or I seek reimbursement from an insurance panel, disclosure of confidential information may be required by your carrier in order to process the claims. Only the minimum necessary information will be communicated. By signing this contract, you are consenting to a release of information about your case to your health insurance provider for claims, certification and case management for the purposes of treatment and payment. I have no control or knowledge over what insurance companies do with the information that is submitted or who has access to this information. You must be aware that submitting a mental health invoice

for reimbursement carries a certain amount of risk to confidentiality and privacy.

CONTACTING ME AND CRISIS NUMBERS

I am often not immediately available by telephone. When I am unavailable, my phone goes to voicemail, which I check several times a day when I am in the office. I make every effort to return your calls within 24 business hours. For emergencies which occur during times when I am not in the office, I can be reached by dialing the crisis number left on my voicemail. This number is usually my cell phone number, unless I am out of the area or unavailable, in which case, the emergency number will reach a colleague covering for me. If you are unable to reach someone during a crisis, you can contact the following: your local physician/hospital, Mobile Crisis 585-275-5151, or the emergency dispatcher at 911.

INFORMED CONSENT FOR TELEPHONE, ELECTRONIC AND MAIL CONTACT:

Ordinary privacy precautions such as pin codes, voicemail boxes, and locked fax, mail, and secured computers are not foolproof; your confidentiality is potentially compromised when communicating by electronic devices or by mail. Neither deletion nor shredding of private material are totally safe means of disposal, so you are always at risk of breaches in confidentiality when electronic or mail communication of any type is used for private information. Your use of such means of communication with me constitutes implied consent for reciprocal use of electronic and mail communication as well. By signing this contract, you agree to and understand the following:

1. Sent and received emails are stored on both my computer and your computer until deleted. I may or may not delete such emails. Any saved emails will be kept in a password-protected account. Alternatively, emails may be printed and placed in the patient's file.
2. In addition, whenever you send an email, it is stored in "cyberspace". It is possible for authorities and system administrators to locate and read such emails under various circumstances. For more information on this, please contact your Internet Service Provider or email service.
3. I often use email as a way to coordinate schedules when attempting to contact teachers or other collateral contacts (when you have given me consent to do so). Protected health information will not be shared via email in a way that connects the information to the patient's identity.
4. By providing your email address, you understand that disclosure listed above regarding communicating with me via e-mail, phone, fax, and mail. You also agree that you send an email to me and request a response via email, that you are willing to accept the above-stated risks. You understand that I cannot guarantee an email response due to time constraints in my practice. You also agree that you will not use email for emergencies. You will utilize email

correspondence with me only for scheduling and non-clinical matters.

WHEN PARENTS ARE IN CONFLICT

Although my responsibility to your child may require my involvement in conflicts between parents, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your child. In particular, I need your agreement that any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me.

Note that such an agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem or law guardian, I will provide information as needed (if appropriate releases of information are signed), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $250.00 per hour for time traveling, preparing reports, testifying, being in attendance, and any other court-related costs.

In the case of separated or divorced parents, one parent must assume full financial responsibility for all services.

INFORMED CONSENT CHILD/ADOLESCENT

Signature Page

Please sign below to acknowledge your informed consent to this agreement.

I have read the above information, received a copy of this form, and have had the opportunity to ask questions which clarify the conditions under which I consent to treatment. I give permission to Emma Forbes-Jones, Ph.D. to provide psychotherapy, evaluation, consultation and/or testing for my child.

Name of Patient: ____

Name of Parent/Guardian: ____

____
Signature of Parent/Guardian Date

Name of Parent/Guardian: ____

____
Signature of Parent/Guardian Date

I also give permission for Dr. Forbes-Jones to initiate/send/place the following to me or relevant parties (with signed release of information):

_____ Email (your address: ____)

_____ Mail

_____ Telephone calls

____
Signature of Parent/Guardian Date

RELEASE OF INFORMATION

Name of Patient Date of birth

I hereby provide authorization for Emma Forbes-Jones, Ph.D. to exchange information regarding the medical and psychological condition of the patient named above with:

Name of Patient's Primary Care Physician

Signature of Parent/Guardian Date