Bryan J. Mall

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Consent for Treatment of Minor(s)

This document is intended to provide information to you regarding the treatment of a minor in your care. Please read the entire document carefully and be sure to ask the therapist any questions you may have regarding its contents.

Information About The Therapist

My educational background includes a Master of Arts degree in Counseling Psychology from Holy Names University. My professional license is in Marriage and Family Therapy with a license number: 102655. You are free to ask further questions at any time about the therapist's professional background, experience, and professional orientation.

Fees and Insurance

The fee for service is $____ per Individual Therapy Session.
The fee for service is $____ per Conjoint (couple/family) Therapy Session.

Individual and Conjoint Therapy sessions are approximately 50 minutes in length, with a 5-minute warning at the end of the session to allow for a proper transition and payment.

Fees are payable and due at the time that services are rendered. Please ask me if you wish to discuss a written agreement that specifies an alternative payment procedure.

Please inform me if you wish to utilize health insurance to pay for services. If I am a contracted provider for your insurance company, I will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although I am happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have regarding this.

If for some reason you find that you are unable to continue paying for your therapy, please inform me and we will discuss potential options that may be available to you at that time.

Confidentiality

If the minor participates in Individual or Conjoint (couple/family) therapy, I will not disclose confidential information about the treatment unless all person(s) who participated in the treatment provide written authorization to release information. It is important to note that I utilize a "no-secrets" policy when conducting Conjoint (couple/family) therapy. This means that I am permitted, not obligated, to use information obtained through individual discussion, when

working with other members of the therapy (spouse, child, etc.). Feel free to ask further questions about the "no-secrets" policy and how it may apply.

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child, dependent adult or elder abuse. Therapists may also be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself.

Minors and Confidentiality

Communications between the therapist and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, the therapist, in the exercise of his professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents/guardians are urged to discuss any questions or concerns that they have regarding confidentiality with the therapist.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different frequency of therapy depending on the nature and severity of your concerns. Consistent attendance greatly contributes to successful outcomes. In order to cancel or reschedule an appointment, you are expected to notify the therapist at least 24 hours in advance of your appointment. **If you do not provide the therapist with at least 24 hours' notice in advance (with the exceptions of illness or emergency), you are responsible for payment for the missed session**. Please understand that your insurance company will not pay for missed or cancelled sessions.

Therapist Availability, Communications, and Emergencies

You are welcome to call me between sessions for emergencies and for logistical items (scheduling, billing, etc.); however, as a general rule, other situations/concerns are better addressed within regularly scheduled sessions. **In the event of a medical or psychiatric emergency, or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance**.

For appropriate e-mail or text communication I will respond to your e-mail or text message within 24 hours; unless previously notified. Potential risks of using electronic communication may include, but are not limited to: inadvertent sending of an e-mail or text containing confidential information to the wrong recipient, theft or loss of the computer, laptop or mobile device storing confidential information, and interception by an unauthorized third party through an unsecured network. E-mail messages may contain viruses or other defects and it is your responsibility to ensure that it is virus-free. In addition, e-mail or text communication may become part of the clinical record. You may be charged for time the therapist spends reading and responding to e-mail or text messages.

About the Therapy Process

It is my intention to provide services that will assist the minor in reaching his/her goals. Based upon the information that you provide to me and the specifics of the situation, I will provide recommendations to you regarding the treatment. I believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I will also periodically provide feedback to you regarding progress and will invite your participation in the discussion. Due to the varying nature and severity of problems

and the individuality of each client, I am unable to predict the length of the therapy or to guarantee a specific outcome or result.

Termination of Therapy

The length of the treatment and the timing of the eventual termination of the treatment depends on the specifics of the treatment plan and the progress achieved. It is a good idea to plan for termination, in collaboration with the therapist. I will discuss a plan for termination with you as the minor approaches the completion of the treatment goals.

You may discontinue therapy at any time. If you or your therapist determine that the minor are not benefiting from treatment, either of you may elect to initiate a discussion of the treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing the treatment plan, or terminating the therapy.

Your signature indicates that you have read this agreement for services carefully, understand its contents, and consent for treatment. Please ask your therapist to address any questions or concerns that you have about this information before you sign.

I state that I am allowed by California law to consent to the mental health treatment of

_____, a minor, age _____, who resides in
(Patient Name)

_____
(City, State, Zip Code)

My relationship to the client is: _____
(Parent, Guardian, Other - explain)

_____ _____
Name of Parent/Guardian Name of Parent/Guardian

_____ _____
Signature Signature

_____ _____
Date Date

_____
Therapist Signature

_____
Date