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PSYCHOTHERAPY SERVICES AGREEMENT FOR ADOLESCENTS

Welcome to my practice. This document sets a frame to clarify how I work with adolescents and their families. Having clearly outlined practices fosters safety and trust in moving forward with your goals.

THE PROCESS OF THERAPY

Psychotherapy is a collaborative process based on the relationship between an individual(s) and a psychotherapist. It provides a supportive environment that allows you to talk openly with someone who is fully present, empathic, and non-judgmental. If clinically useful and everyone agrees, I sometimes ask other family members to join a session to help further the adolescent's progress in therapy.

In our first sessions (2-4), we will talk about what brings you to therapy, your personal and family history, and desired outcome. Sometimes, the assessment process involves forms, questionnaires, and psychological tests to be completed by parent(s) and/or the adolescent. During this time, we can decide if I am the best person to provide the services you need in order to meet your goals. My goal is to bring a fresh perspective and clinical flexibility regarding how best to proceed with therapy, employing techniques and tools customized to your situation.

Psychotherapy can have benefits and risks. Therapy often leads to greater self-understanding, better relationships, solutions to specific problems, and significant reductions in feelings of distress. Such benefits may require substantial effort on the part of the adolescent and his/her family— in and outside of session – including openness and a willingness to explore difficult issues and family dynamics. I may offer observations or invite you to examine long-held assumptions, perceptions, and behaviors and may offer different perspectives. I encourage you to share your reactions and feelings as they arise in our work together.

During the therapy process, some patients find they feel worse before they feel better. Remembering or talking about unpleasant events, feelings, or thoughts, may result in your experiencing discomfort or strong emotion, such as anxiety, anger, or sadness. It is common to experience a range of feelings towards the therapist as well. This generally is a normal course of events and I encourage you to bring these matters up in session. My intention is to work supportively with you and to honor and trust your unique journey in therapy.

Personal growth and change may be easy and swift at times, but also may be slow and frustrating. Exploring the issues you bring to therapy may have other unintended outcomes, including increased conflict or difficulty in academic, social, and family relationships. Sometimes a decision by or change in one family member can disrupt other relationships. I endeavor to support you emotionally and to help you discover your own inner wisdom throughout the therapeutic process.

Adolescents in psychotherapy benefit from having a support system, including family, friends, a supportive school environment, and in some cases, spiritual affiliations. Expressive activities, such as sports, art, writing, music, etc. are also important for healthy adolescent development. Other treatment options such as family therapy, group therapy, 12 step groups, support groups, and medication may be helpful. I will refer you to outside community resources as needed.

When possible, I use methods that research has shown to be effective and will discuss appropriate treatment alternatives with you. I invite feedback throughout therapy about what is and what is not working for you. I welcome questions about techniques used in therapy, my background and experience, my theoretical orientation, or any other concerns you may have.

Initial here if this section has been read and understood _____

CONFIDENTIALITY

What you share in therapy is generally confidential and will not be released to any third party without your written authorization except where required or permitted by law. I will not tell anyone what you have told me, or even that you are in therapy with me, without your prior approval, subject to the following legal exceptions:

1. If I have a reasonable suspicion that there is suspected past or present child, dependent, or elder abuse or neglect.
2. If you are a serious danger to yourself or to the person or property of another, or are no longer able to care for yourself, I may choose to break confidentiality to garner the necessary support to ensure your safety.
3. If you make a serious threat of violence towards a reasonably identifiable victim, then I must notify the police and the intended victim.
4. If I receive a court order in a legal proceeding, I must provide the requested information.
5. If there is disclosure of a sexual nature involving minors that meets the criteria for a report. Please ask for specific information.
6. In an emergency, I may provide needed information to medical personnel.

You should also be aware that I will not voluntarily participate in any litigation, or custody dispute in which you and/or your family and another individual, or entity, are parties. I have a policy not to communicate with your attorney and will generally not write or sign letters,

reports, declarations, or affidavits to be used in your legal matters. Should I be subpoenaed to appear as a witness or to provide any records of your therapy, I will assert your confidentiality rights until instructed, in writing, to do otherwise by a person with the authority to waive the privilege on the adolescent's behalf. If I receive a court order, I would be required to comply with the order for records and/or testimony. Limiting my involvement in legal matters creates appropriate boundaries around my role as your therapist and prevents conflicts of interest so that I can provide quality therapy for you.

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The need for adolescent confidentiality with parents/guardians

To build a strong working relationship for optimal treatment, it is important to clarify with parents and adolescents the expectations regarding confidentiality. In general, I will keep the content of your minor's sessions confidential to allow your child to confide in me and for therapy to be effective.

With adolescents, there are certain issues that I would have limited opportunity to address unless your minor trusts that communication in therapy will not be shared with parents or guardians. These issues can include use of cigarettes, alcohol and drugs, self-harming behaviors, suicidality, eating disorders, sexual concerns or behavior, involvement in gangs, cutting classes or truancy, school failure, unauthorized time with peers, and criminal activity.

I will work with your minor child to help him/her behave in ways that are not self-destructive, that do not limit his/her options for the future, and that are considerate of others. If any of these issues rise to the level of serious danger to self or others, I will notify parents and or appropriate authorities. When I feel that it is important to have certain information shared with parents, the minor will be encouraged to do so and family sessions may be held to facilitate this process.

Periodically, I will provide parents with general updates on progress, share information that the minor has authorized, and/or work with parents on how they can be helpful in furthering their adolescent's treatment. I encourage parents to contact me with any concerns or observations that they feel would be important for me to know about.

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COLLATERAL CONTACT WITH PARENTS AND OTHERS

The parent's contact with me is supplemental and for the purpose of assisting with the adolescent's treatment. I am not treating parent(s), although I will hold family meetings or consult on specific issues when appropriate. As a "visitor" in your minor's treatment, you may not have the same confidentiality rights afforded to your adolescent child who is the client, although I would not ordinarily disclose information obtained from parents and family members to any third party.

It is important for you to know that many issues affecting adolescents are influenced by family dynamics and I often need to speak with everyone involved in order to help you and your family make progress. I will provide you with referrals for parent(s)/family therapy if requested by you or if this is indicated.

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CONSENT TO TREAT MINOR

I generally require consent of both parents before providing psychotherapy to a minor, whether you are married, separated, or divorced. If parents are divorced, **I will need a copy of the custody agreement** or other supporting legal documentation before proceeding. Having both parents play a supportive role in their adolescent's therapy is a vital component of successful treatment.

Treating Adolescents of Separated or Divorced Parents

Treating adolescents from families that are adjusting to separation or divorce poses special challenges as we work to promote healthy adaptation to change. Sometimes parents have different perspectives on their adolescent's needs or fear that I may side with the other parent. For these reasons, I have the following policies for treating children of separated or divorced parents who share legal custody:

1. Both parents must consent to treatment, ideally before the first session with the adolescent, or shortly thereafter.
2. Both parents will be offered contact with the therapist as much as is clinically advisable, unless this is contraindicated, such as in cases in which the therapist determines that contact with one or both parents might negatively affect the adolescent (e.g., if there is a concern regarding parental abuse or threats to the adolescent).
3. I will not communicate with attorneys for either parent or guardian and generally will not write or sign letters, reports, declarations, or affidavits to be used in your legal matters.
4. Information provided by one parent may be shared with the other parent, if it is clinically advisable to do so.
5. I will not voluntarily participate in any litigation or custody dispute or provide custody or visitation recommendations to the court, mediator, and/or psychologist conducting a family psychological evaluation.

These policies may not apply when a parent resides out of the area or when a parent fails to respond to my attempts to establish contact with that parent.

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PROFESSIONAL CONSULTATION AND COLLABORATION

Sometimes I will consult, collaborate with, and/or refer to psychiatrists, physicians, and other professionals on clinical, ethical, and/or legal matters to provide the most effective care. I receive and give regular case consultation. I also may refer you to outside community resources for support. During my work with third parties, I will not reveal any identifying information about you unless you have provided me with written permission.

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RECORDS

The laws and standards of the psychotherapy profession require that I maintain clinical and business records. Your adolescent and you are entitled to have access to these records unless I believe that seeing them would be emotionally damaging to your adolescent or that parental review of records could harm the adolescent or the therapeutic relationship with the adolescent.

If the adolescent or parent(s) makes a written request for records, I legally may respond by 1) allowing you to review the records; 2) giving you a copy of the records; or 3) providing you with a summary of the records. If I believe that seeing the records would not be in the adolescent's best interest, I may instead provide a copy of the records to another treating health care provider of your choice. Clients will be charged an appropriate fee for responding to the request for records. I will maintain the adolescent's records for ten years following the end of therapy. After ten years, I will destroy the records in a way that preserves your confidentiality.

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PROFESSIONAL FEES

My usual fee for a 50-minute session of individual therapy is $130.00. This fee includes record keeping, preparation, and collaboration with other professionals. Fees for longer or shorter sessions will be prorated from this amount.

There will be no charge for brief telephone calls lasting 10 minutes or less, such as those to make or change an appointment. However, you will be charged the typical session fee (prorated according to length) for calls longer than 10 minutes. I periodically adjust my fees and I will notify you at least one month in advance of any anticipated fee increases. I encourage you to discuss fees with me at any time.

The agreed on fee for your therapy is _____ per 50-minute individual session.

If you become involved in legal proceedings requiring my participation, you are expected to pay for my professional time, even if I am called by another party. Because of the difficulty of legal involvement, I will charge my normal hourly rate for preparation and attendance.

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BILLING AND PAYMENTS

Payments are to be made at the beginning of each session, unless other arrangements have been made. I accept payment by cash, check, or credit cards, including Visa and MasterCard. I request that your check be made out in advance so that our time may be spent attending to your therapy.

If you pay by check and it is returned for insufficient funds, there will be a $30 fee. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option to use legal means to secure payment for services already provided. This may involve hiring a collection agency or going through small claims court. If legal action is necessary, its costs will be added to the claim. In most collection situations, the only information I would release regarding your treatment is your name, the nature of services provided, and the amount due. I can terminate treatment if you fail to pay for services.

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INSURANCE

To set realistic treatment goals and priorities, it is important to evaluate what resources the family has to pay for the adolescent's treatment. I am not a contracted provider with any insurance company or managed care organization at this time. If you have a health insurance policy, it may provide you with some reimbursement for mental health treatment given by an "out of network" provider. It is vital for you to find out exactly what coverage for mental health services your company provides.

Should you choose to use your insurance, I will provide you with a statement, which you can submit to the third-party of your choice, to seek reimbursement of fees already paid. It is your responsibility to complete insurance forms and to obtain reimbursement. You (not your insurance company) are responsible for full payment of fees at time of service.

You should be aware that insurance companies vary in what information they may ask me to provide, but many require a diagnosis, treatment plans/summaries, or, in rare instances, copies of the record. This information becomes part of the insurance company's files. Though all insurance companies claim to keep such information confidential, I have no control over how they handle such information. I will not offer any confidential information to your insurance company without first discussing this with you and your minor and receiving written permission to do so.

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APPOINTMENT SCHEDULING AND CANCELLATION POLICY

Weekly regularly scheduled sessions typically work best, especially in the earlier phases of therapy. However, we may agree to schedule sessions more or less frequently depending on

your needs as therapy progresses. Your consistent attendance greatly contributes to successful outcome. Once an appointment is scheduled, you are expected to pay for it unless you provide me with notice 24 hours in advance. Please understand that your insurance company will not reimburse you for missed or cancelled appointments.

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THERAPIST AVAILABILITY AND EMERGENCIES

I usually am not immediately available by telephone. My telephone number, (415) 820-1612, is typically answered by confidential voicemail, which I monitor frequently. I will make every effort to return your call within 24 hours during regular working hours (M-F, 9 a.m. – 6 p.m., excluding holidays). I return weekend calls on Mondays.

I am not able to provide 24-hour crisis service. If you feel unsafe or that you need immediate help, call the Psychiatric Emergency Services Unit at Marin General Hospital at (415) 499-6666, the Suicide Prevention and Community Counseling Hotline at (415) 499-1100, or 911. These are crises lines that are answered 24/7. You also can go to your nearest emergency room.

If I plan to be away or am unavailable due to an urgent matter, I will give you advance notice and also will provide you with the name of a colleague to contact if necessary.

Initial here if this section has been read and understood _____

EMAIL DISCLOSURE

I use email to schedule appointments only and not to discuss clinical matters. If you choose to use email to make or cancel appointments, please know that your confidentiality cannot be assured because email cannot be transmitted on a secure server.

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ENDING THERAPY

Therapy is always your choice. You have the right to end therapy at any time, for any reason. I also may choose to end therapy under certain circumstances, including, untimely payment of fees, conflicts of interest, failure to benefit from treatment, or if needs emerge that are outside of my scope of competence or practice. Whether your goals have been met or therapy is concluding for another reason, I highly encourage you to participate in one or more ending sessions, to reflect on your progress and provide a positive end to therapy.

Initial here if this section has been read and understood _____

I welcome you to our work together and anticipate a collaborative and beneficial working relationship.

_____ _____

Rebecca Johnson, LMFT Date

I have read and understand the above Psychotherapy Agreement for Adolescents. I have discussed the provisions of the agreement with my therapist and have had my questions answered to my satisfaction. I accept and agree to abide by the terms of the agreement and by signing below hereby consent to treatment.

_____
Minor Name (please print)

_____ _____
Signature of Minor Date

_____/_____ _____
Signature of Parent or Guardian Relationship to Minor Date

_____/_____ _____
Signature of Parent or Guardian Relationship to Minor Date

I understand that I am financially responsible to the therapist for all charges, including unpaid charges by my insurance company, or any other third-party payor.

_____
Name of Responsible Party (please print)

_____/_____ _____
Signature of Responsible Party Relationship to Minor Date