# Consent for Counseling Treatment

melmed center

Introduction

Welcome! As a new patient, we look forward to working with you, your family, and your child(ren). The purpose of this form is to let you know about the counseling process. This form is also to request your consent for treatment and clarifies the agreement of procedural and financial terms as stated below.

Therapy

The relationship between feelings, thoughts, and behavior is crucial to understanding the issues that affect being successful in life. Your treatment provider may utilize a variety of strategies including psycho-educational, cognitive behavioral, psychodynamic, interpersonal, play, sandtray, family, and group approaches, while integrating developmental and biological influences. It is important to understand an individual from his or her own unique biological, social/emotional, familial, cultural, environmental experience.

Individual, child, and/or family therapy can offer you or your family members a chance to express ideas and concerns to better understand your situation and to learn new ways to solve problems. However, there are sometimes risks within this process. Success of the therapy process will be influenced by the time, effort, and willingness of all who are involved. As therapy is a collaborative process, communication is imperative to discuss expectations, determine goals, and evaluate progress. At times, you or your child might experience feelings that are uncomfortable and difficult. Your treatment provider is available to discuss these concerns openly with you and will provide an accurate and fair assessment that will help guide your treatment-planning/goal setting.

Treatment Planning

A treatment plan will be developed collaboratively with you [and your child(ren), if developmentally appropriate] in an effort to identify treatment goals and provide a guide for the treatment process. These goals provide a focus for treatment and will be evaluated throughout the course of treatment with your input to ensure satisfactory progress is being achieved. Your written consent will be obtained for each treatment plan. At the close of treatment, a brief summary will be placed in your child(ren)'s medical chart reflecting his or her overall progress in therapy.

Limits of Confidentiality

Information that is discussed with your treatment provider is confidential and can only be released to others outside of Melmed Center with your written consent, or as authorized by law. There are some exceptions to confidentiality. Confidentiality is limited in matters pertaining to: (1) threat of harm to self or to another person; (2) physical/sexual abuse or neglect of minors, persons with disabilities, and the elderly-current or past; (3) legal activity resulting in a Court order; or (4) in accordance with the law. Your treatment provider is a legally mandated reporter of abuse to a minor or elderly person



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**Consent**

**As children are part of a family system, decisions about care, medical, educational, etc., must be made by the child's parents/legal guardians. In the event of a parental separation or divorce, both parents MUST consent, in writing, to counseling services. Your treatment provider invites and encourages both parents (as they are able) to participate in the process of treatment planning, therapy, and evaluation of outcomes. If one parent retains sole legal custody, this parent MUST provide documentation of this in order for therapy to proceed. In the case of joint custody, both parents MUST consent to treatment.**

Procedural and Financial Issues

I understand that at the Melmed Center, the clinicians wish to answer my questions clearly and completely. I am free to ask for clarification of any results, opinions, findings, or recommendations at any time. I understand that I may communicate openly with my treating clinician(s), and that I may terminate the evaluation, therapy, or intervention at any time after discussing my concerns with the clinician(s). Your treatment provider can assist you in making appropriate treatment referrals, etc. and will work with you and your child(ren) to terminate therapy in a clinically appropriate manner.

Since the clinicians at the Melmed Center can best serve patients when up-to-date medical, educational, and psychological information is available, I consent to have the treatment provider review all records related to care, growth, and development of the patient, which may include my child's medical chart. I also consent for the treatment provider to consult with any other treating clinicians within the Melmed Center, who are working with my child(ren), in an effort to provide optimum care. I agree to provide all relevant information including, but not limited to; personal knowledge, intake summaries, treatment plans, progress notes, psychological and developmental history, medical records, physical examinations, psychiatric and psychological evaluations, consultation reports, psychological test results, diagnostic records, educational, social, vocational, speech, occupational and physical therapy records, and legal records.

Counseling sessions run approximately **50 minutes** in length and are billed at **$195.00 per session** with a licensed Psychologist. Letters requested from your treatment provider are billed at **$60.00** (e.g. to school or child's teacher, for another treatment provider, treatment summary, etc.). If this treatment is court mandated and/or you anticipate that there will be legal involvement that might include a report/treatment summary, testimony, and/or consultation with case manager, probation officer, attorney, etc., there is a retainer for all Court involved cases and fees associated with the aforementioned services. Please see the front office for more details. The mental health clinicians do not participate with third party payers, such as managed care organizations and insurance companies. By signing this form, you are agreeing to pay this fee before each session. Cancellations must be made **48 hours** in advance! You will be billed **50%** of the scheduled service for a late cancellation or missed appointment, as this time has been reserved especially for you and your child.

Please note that if your treatment provider is not available, you can leave a message at 480-443-0050, and she or he will get back to you as soon as possible, usually within 24-48 hours. In the event of an urgent clinical matter and your treatment provider is not available, you may contact your treating physician or the physician on call (if after hours). In the event of an emergency, please call 911.

Records Maintenance

Melmed Center is a multi-disciplinary practice with clinician's who strive to work collaboratively in an effort to provide optimum treatment and care. Your child's treatment records are maintained as part of your child(ren)'s medical record in an effort to coordinate care with all of your child(ren)'s treatment providers at Melmed Center. Records will be maintained at Melmed Center for a **minimum of three years** past the child's 18th birthday OR for at least **seven years*** from the date of the last visit, **whichever is longer.** For adults, records are retained for at least **seven years*** after the last date the adult patient received services. *(Please note, that the Arizona Revised Statute 12-2297 states 6 years is required by law to retain records, however, Melmed Center aspires to a higher standard of care and retains records for seven years).

My child, myself, or my family has presented to the **Melmed Center** for an assessment and/or treatment for:

_____ Individual Therapy
_____ Family Therapy

***Minor or Individual With a Custodial Guardian***

I, the parent or guardian of _____ understand and agree to the information regarding confidentiality and financial responsibility. I hereby consent to therapeutic services.

_____ _____

Signature Date Signature of second person Date

***Adult***

I/We _____ understand and agree to the information regarding confidentiality and financial responsibility. Thus, I hereby consent to receive therapeutic services.

_____ _____

Signature Date Signature of second person Date

***Treatment Provider(s)*:**

_____

Date

Psychologist: