Andrea L. Schneider, LCSW
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CONFIDENTIAL INFORMATION

CHILD CONSENT FOR TREATMENT

I/We_____, the Parent(s)/Guardian(s) of _____ do hereby express my/our understanding that _____(Minor) is to receive psychotherapy/counseling services provided by Andrea Schneider, LCSW beginning _____(date of first visit).

As a client, the Minor Child is entitled to a confidential therapeutic relationship. As Parent/Guardian, I am welcome to discuss any concerns I have regarding the treatment the Minor is receiving.

Appointment Fees: Therapy sessions consist of a 50 minute hour (in some cases 90 minutes, i.e. for family therapy session). The fee for a 50 minute hour is $120.00. The fee for 90 minutes is $170. Payment for services is due and payable at the time professional services are rendered. Please have payment for your child's services (cash or check) ready at the beginning of the session so our attention can be given immediately to the work at hand. If I encounter a problem with the payment I, as the parent, will discuss it immediately with the therapist. Appointments cancelled or rescheduled with less than 24 hours notice may be charged a cancellation fee of $70.00. Insurance will not pay for a "no-show" for session; therefore, I am responsible, as Parent of Minor Child, for the full amount of the fee if child "no-shows" for a session.

Insurance Reimbursement: It is my responsibility, as Parent of Minor Child, to check with my child's insurance company to determine if there is coverage for mental health, the amount of the annual deductible, if it has been covered at the time of service, and if additional documentation is required. I am responsible for the co-payment at the time of the service. I understand what may be quoted by my child's insurance company may not be the actual payment to the therapist, and I will be fully responsible for payment if insurance does not pay the claim for service.

Confidentiality: All information disclosed within the client's therapy sessions, including case notes and records, will be treated as confidential and, under some circumstances, as privileged. No information will be revealed to anyone not present in therapy without the permission of the client or a legally authorized representative unless there is an applicable legal or ethical exception. However,

the therapist is required by law to report any suspected child, elder, or dependent adult abuse and any situation where the client threatens violence to an identifiable victim. The law also permits the therapist to break confidentiality when the client presents a danger of violence to others or is likely to harm him or herself unless protective measures are taken. In addition, disclosures may be required in certain legal proceedings and actions. All questions regarding confidentiality, the release of information and waiver of privilege, etc., need to be brought up with the therapist.

Termination: The client's therapeutic and financial relationship with the therapist continues as long as the therapist is providing professional services until the client and client's parent(s)/guardian(s) inform therapist that the client wishes to terminate therapy, or the therapist notifies the client that therapy is being terminated.

I agree to have my child meet with the therapist at least once before stopping therapy. I understand that this requirement is in my child's best interest. I, as parent(s)/guardian(s) agree to pay for all services provided up until the time the therapy relationship is terminated.

The treatment consists of weekly sessions, unless otherwise determined mutually by therapist, Minor Child Client, and client's parent/guardian.

I have read and understand all of the terms and conditions stated above regarding therapy. All my questions have been answered fully. I understand and agree to the terms and conditions of this treatment.

_____ _____ _____

Signature of Client Printed Name Date

_____ _____ _____

Signature of Parent/Guardian Printed Name Date

I have disclosed the above issues with the client (Minor Child) and the client's parent/guardian. My observations of this child's and parent/guardian's behavior and responses give me no reason to believe that child and parent/guardian of Minor Child are not fully competent to give informed and willing consent to treatment for Minor Child.

_____ _____ _____

Signature of Therapist Printed Name Date

__ Copy given to Client/Parent/Guardian ____Copy kept by therapist