



## **Parent Informed Consent**

*For use when the parent presents a minor for services.*

*When minors, 12 or older, present themselves for therapy use the Youth Informed Consent form.*

### **Confidentiality**

We honor the importance of your family's confidentiality in the counseling process. We want you to know that any information you or your child share is protected by professional and ethical standards, and will not be released without your written consent. The only exceptions to this are to protect the safety of you, your child and others. We may need to report reasonable suspicion of child abuse; elder abuse; dependent adult abuse; or intervene if you present a danger to yourself or to others; or by court order.

### **Consultations & Supervision**

Clinical services are provided by clinicians who are either currently licensed or who are in training to become licensed therapists. Our clinical group supervisors\* provide supervision to our unlicensed clinicians on a weekly basis. Additionally, your clinician may have an individual supervisor. Ask your clinician if you want to know who their individual supervisor is. During supervision meetings, your information may be discussed. All information shared between clinicians, supervisors and administration is handled confidentially within our agency. \*(Jenn Farley, LPCC #2700, Tim Hartnett, LMFT #27228)

### **Emergency Contact Policy**

Please note that Shine a Light Counseling Center is not a crisis counseling center or an emergency provider. If you or your child experience a mental health crisis, please call the Santa Cruz County Access Team (Santa Cruz county) at 800-952-2335, Monterey County Mental Health Crisis Line (Monterey county) at 831-755-4111, Suicide Prevention at 877-663-5433, or 911.

### **Contacting Your Counselor**

Please call your counselor's direct phone number, as that is the best way to assure they receive your message in a timely manner. Be sure to get your counselor's contact information directly from them. Do not call the Shine a Light main phone number to communicate with your counselor or give notice about late arrivals or cancellations.

### **Fees & Payment**

Your counseling fee is set by your counselor according to agency policies. Payment of the fee is due at each session. Cash, check, and credit/debit cards are accepted. There will be a \$25.00 fee charged for any returned check. Unfortunately we are unable to bill for services, or allow a client to "carry" a balance owed. And we do not refund payments for missed appointments or late cancellations.

Please input the fee agreed upon with your counselor \$ \_\_\_\_\_/session.

### **Late Cancellations & Missed Appointments**

Cancellations must be made 24-hours in advance. If an appointment is canceled or missed without 24-hours of notice, you will be charged your usual session fee for that missed session. If you or your child arrive late for the appointment, the session will be shortened in order to finish on time.

\_\_\_\_\_ Initials

### **Session Length**

Your session length is 50 minutes. If you require a longer appointment, your counselor can work with you to determine an appropriate length of time; and the fee will adjust accordingly.

### **Child Custody, Legal Proceedings, and Costs**

It is the policy of Shine a Light Counseling Center not to participate in any litigation, including child custody evaluations/recommendations. We do not voluntarily testify in any court proceeding or disposition. We generally do not write or sign letters, reports, declarations, or affidavits to be used in any legal matter. If any officer or employee of Shine a Light Counseling Center is called to testify or provide disposition in court, proceeding, or other meeting on your behalf, Shine a Light Counseling Center charges \$250.00/hour and reasonable travel and hotel costs for any and all related time spent on the case.

### **Your Counseling Experience**

Counseling is a unique and highly individualized experience. Please let your counselor know anything you feel is important for them to know about your child, including their reactions to the therapy. Your openness and honesty are important for a healthy therapeutic relationship.

### **Ending Therapy**

You have the right to discontinue therapy at your discretion. And there are some conditions under which your counselor may recommend termination. If you decide to stop therapy, your counselor will generally recommend that you or your child participate in one or more (optional) closing sessions. These sessions are an opportunity to reflect on the work that has been done, and to discuss next steps, including possible referrals for alternative sources of support.

### **HIPAA Notice of Privacy Practices**

This notice describes how medical information about you may be used and disclosed electronically and how you can get access to this information. Please review it carefully.

1. We have a legal duty to safeguard your protected health information (PHI) when we transmit information electronically. We are legally required to protect the privacy of your PHI, which includes information that can be used to identify you that we've created or received about your past, present or future health or condition, the provision of health care to you, or the payment of this health care.
2. We must provide you with this Notice about our privacy practices, and such Notice must explain how, when and why we will "use" and "disclose" your PHI. A "use" of PHI occurs when we share, examine, utilize, apply, or analyze such information within our agency; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of our agency. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made.
3. By signing this notice you acknowledge we may use your PHI, but may not disclose your PHI without further written authorization by you. We do not keep separate treatment notes and psychotherapy notes; all of our notes can be found in the client file. Your PHI will not be disclosed for marketing purposes. If you pay for any service out-of-pocket, then you have the right to restrict disclosures of PHI to health plans from that service. If there is a breach of your unsecured PHI, you will receive notification.
4. However, we reserve the right to change the terms of this Notice and our privacy policies at any time. Any changes will apply to the PHI on file with us already. Before we make any changes to our policies, we will promptly change this notice and post a new copy of it in our offices and on our website. You can also request a copy of this notice from us, or you can view a copy of it in our office or on our website. Please sign this Notice, stating that you acknowledge receipt of this Notice of Privacy Practices of Shine a Light Counseling Center.

# Consent to Treat a Minor

*If the caregiver presenting the child for therapy is not the parent or legal guardian, please use the Caregiver's Affidavit instead of this form.*

The undersigned is the responsible parent or legal guardian and hereby authorizes Shine a Light Counseling Center and its staff to provide counseling to the minor stated below. The parent or legal guardian understands that while a therapy session is based on a 50-minute long hour, some young children benefit from shorter sessions. The parent or guardian further recognizes that the transportation to and from, and the supervision of the child (or children) before and after session, is the sole responsibility of the parent or guardian. Shine a Light Counseling Center does not allow unaccompanied children in the waiting room without direct parental supervision.

If the parents are divorced, the parent signing testifies that they either have sole legal custody or they have informed and gained consent of the other parent for the child's therapy.

Name of Minor \_\_\_\_\_ Date \_\_\_\_\_

Name of Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Name of Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

**BBS Notice to Clients:**

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at [www.bbs.ca.gov](http://www.bbs.ca.gov), or by calling (916) 574-7830.

# Credit Card Payment Agreement

**Please note:** All clients are requested to keep a valid credit card on file. Please complete the following information.

**Credit Card Type:** \_\_\_ Visa \_\_\_ MasterCard \_\_\_ American Express \_\_\_ Discover

**Name on Card:** \_\_\_\_\_

**Credit Card #:** \_\_\_\_\_

**3 Digit Security Code:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_

**If American Express, 4 Digit Code on Front of Card:** \_\_\_\_\_

**Street Address Associated with Card:** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**This card may be used for the following (initial all):**

\_\_\_\_\_ Regular session fees

\_\_\_\_\_ Same day cancellations or no-show appointments

\_\_\_\_\_ Delinquent sessions (more than 30 days overdue)

\_\_\_\_\_ I understand there are no refunds given

I \_\_\_\_\_ have read and understand the terms of providing my credit card to Shine A Light Counseling Center. I understand that my credit card may be charged for the reasons indicated above. I also understand there are no refunds given. Any questions I have about this practice have been answered and I give my full consent to charge my credit card under the circumstances above. This agreement is valid until termination of services.

**Your electronic signature, when you upload this form,  
indicates your agreement to this entire document.**