Instructions for using the Document Portal:

1. Put your mouse in the blue area of the portal and make sure you scroll down
   to see the download/upload buttons.
2. Download the file and save it to your computer somewhere (e.g., the desktop).
3. You must open it from your computer after you have downloaded (instead of clicking on the link on the portal) to fill it in.
4. You can fill it in from the PDF, but, again you have to save it to your computer in order for the form fields to work.
5. You are welcome to download, fill it in with ink, and scan it, upload it back to the portal if you prefer.

Laura Jansons, Psy.D., A.B.N.

Clinical Neuropsychologist

355 W Dundee #210 ◆ Buffalo Grove, IL 60089

224-636-6333

PATIENT INSURANCE INFORMATION

Patient Name _____ DOB _____Gender _____

Parent Name (IF CHILD PATIENT) _____

Problem_____

Referred By _____

Type of service:

☐

☐

☐ Psychotherapy Requested CPT CODES: 90791 and 90837

Primary Insurance Information (BCBS only)

Insurance _____ Policyholder _____

Policy /ID Number_____ Policyholder DOB _____

Group Number _____

- DR JANSONS ONLY HAS ABILITY TO PROCESS BLUE CROSS CLAIMS
- FOR OTHERS WITH DIFFERENT POLICIES, SHE IS CONSIDERED OUT OF NETWORK
- DR JANSONS DOES NOT KNOW HOW MUCH YOUR INSURANCE WILL PAY AND WILL NOT BE ACCOUNTABLE FOR KNOWING YOUR DEDUCTIBLE, COPAYS ETC. PLEASE CONTACT YOUR INSURANCE DIRECTLY.

CREDIT CARD AUTHORIZATION

PATIENT NAME:_____

DATES OF SERVICE:_____

NAME ON CREDIT CARD: _____

CREDIT CARD TYPE:_____

CREDIT CARD NUMBER:_____

EXP DATE:_____

SEC CODE:_____

BILLING ZIP CODE:_____

I AUTHORIZE THE USE OF THE ABOVE CREDIT CARD FOR SERVICES RENDERED, TO INCLUDE COPAYS, COINSURANCES, DEDUCTIBLES, AND CHARGES NOT COVERED BY INSURANCE.

AMOUNT TO BE BILLED (if known):_____

SIGNATURE_____

DR JANSONS OFFICE HAS NO WAY OF GUARANTEEING YOUR INSURANCE WILL PAY.

INSURANCE COMPANIES ONLY VERIFY YOU HAVE COVERAGE BUT WILL NEVER FINALIZE OR PROMISE ANYTHING IN REGARDS TO WHAT THEY ARE WILLING TO PAY UNTIL **AFTER** THE SERVICE IS CHARGED.

OUR OFFICE WILL NEVER SPEAK ON BEHALF OF INSURANCE OR QUOTE/ GUARANTEE WHAT YOUR INSURANCE COMPANY WILL END UP PAYING. WE ARE NEVER GIVEN THAT INFORMATION PRIOR TO THE SERVICE--**BECAUSE IT DOES NOT EXIST.** COPAY/DEDUCTIBLE/COINSURNACE RESEARCH IS THE RESPONSIBILITY OF THE POLICY HOLDER NOT DR JANSONS OFFICE.

Dr. Laura Jansons
Neuroscience and Psychological Services

355 W. Dundee Rd
Suite 210
Buffalo Grove IL 60089
224-636-6333

These are instructions for how to fill out the release of information below
Completing a release of information is optional, see form below.

Specific information about disclosures and dates shall be documented in the individual's clinical record or Disclosure Tracking System.
A facsimile of this original shall have the same force and effect as the original.

The Standards for Privacy of Personally identifiable Health Information, 45 CFR Parts 160 and 164, states that information used or disclosed pursuant to this authorization may be subject to a re disclosure by the recipient of the information. The federal confidentiality Rules 42 CFR Part 2 prohibit making any further disclosure of drug or alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 1. A general authorization for the release of medical or other information DOES NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52FR21809, June 9, 1987; 52 FR4 1997, November 2, 1987)

NOTE: Your refusal to sign an Authorization to Disclose/Obtain Information will not prevent treatment, payment, or enrollment in a health plan or eligibility for benefits

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INSTRUCTIONS: Authorizations to Disclose/Obtain Information

(1) Identify whether the form will be used to disclose, to obtain or to disclose/obtain (share) information and whom you are authorizing to perform this function.

(2) Check the specific information you wish to disclose/obtain. Check only what is the minimum necessary to fulfill the purpose of disclosure. Enter a service date - if unknown, indicate "last service date" and only checked information from last service dates will be released or obtained.

(3) Complete the individual's name, date of birth, social security number and aliases or a maiden name to help correctly identify the individual.

(4) Check the purpose or reason why the information needs to be disclosed/obtained.

(5) Circle all manners which the information may be disclosed/obtained. If you wish to restrict any of these, please specify. If nothing is specified, all manners of release will be considered authorized. (Information will only be faxed if URGENT.)

(6) Complete the name and address of the agency, facility or person to whom you will disclose the information or complete the name and address of the agency, facility or person from whom you are obtaining the information. If you wish it to be phoned or faxed, include area code and numbers.

(7) Complete the calendar date (month, day and year) on which this authorization will expire. Information cannot be disclosed/obtained without a specific date of expiration.

(8) Sensitive information will be released/obtained unless you specifically check an exclusion. **If no items are checked all information within the patient record is subject to disclosure.**

(11) Self-explanatory. (10) Self-explanatory. (11) Self-explanatory.

NOTE: In accordance with federal and state privacy laws only the following persons shall be entitled to consent in writing to the inspection, copying and/or the release of the individual's protected health information.

- The individual if they are 12 years of age or older.
- The parent or guardian of an individual less than 12 years of age **(If both parents have co-custody, both individuals must sign - one on line 13, the other on line 14.)**
- The parent or guardian of an individual between the ages of 12 and 17, provided the individual does not object and has signed the authorization.
- The guardian of a person 18 years of age or older.
- An attorney or guardian ad litem who represents a minor 12 or older provided the court has entered an order granting this right.

(12) Individual to sign and date here if - age 12 or older.

(13) Parent to sign and date here if -

- Individual is less than 12 years of age or
- If individual is between 12 and 18 and has signed on line 12 or Guardian to sign here if -
- If individual is 18 years of age or older but is legally disabled. **You must provide a copy of the Guardianship court order granting you this right.**

Guardian to sign here if -

- If you are a guardian ad litem or attorney representing a minor 12 or older in any judicial or administrative proceeding. **You must provide a copy of the court order granting you this right.**

(14) Witness to sign and date here. **All authorizations require a witness signature to attest to the identity of the person entitled to give consent** (person signing line 12/13) **Line may be used by a co-custodial parent.**

(15) Staff person disclosing/obtaining information signs here. Specific dates when disclosed/obtained shall be documented in the individual's clinical record and/or the Disclosure Tracking system.

Dr. Laura Jansons
Neuroscience and Psychological Services
355 W. Dundee Rd
Ste 210
Buffalo Grove IL, 60089
224-636-6333

Complete only if you want Dr. Jansons to release report to someone (MD, therapist, etc) or if you would like her to receive information from someone. Instructions on previous page.

Authorization to Disclose/Obtain Information

(1) I authorize _____ to ☐ disclose ☐ obtain ☐ disclose and obtain
(Hospital/Agency/Individual)

(2) ☐ Discharge Summary ☐ Discharge Staffing ☐ Psychiatric Evaluation ☐ Social History ☐ History and Physical
☐ Treatment/Hab Plans ☐ Assessments (Specify Type) _____ ☐ Physicians Orders
☐ Med. Administration Records ☐ Progress Notes ☐ Behavioral Plans ☐ Consultations ☐ Lab/X-Ray
☐ Photos ☐ Record Abstract ☐ Patient Review ☐ Other (specify) _____

Concerning the care of the below named person from DATE (or RANGE OF DATES): _____

(3) About (Name) _____ Social Security Number: _____
Date of Birth: _____ Alias: _____

(4) For purposes of: ☐ Personal Use ☐ Continuity of Care ☐ Placement Transfer ☐ Financial/Benefits
☐ Attorney ☐ State Law/Court ☐ Death ☐ Other (specify) _____

(5) Information may be disclosed/obtained: Mail, In-Person, Phone, E-Mail or by Fax (For Urgent/Emergency Needs). *Restrictions if any:*
_____

(6) ☐ Disclose To	☐ Obtain From
Name:	Name:
Address:	Address:
City/State/Zip:	City/State/Zip:

(7) This authorization is valid until calendar date: _____ _____ _____
Month Day Year

(8) It is my full understanding that the records and communications to be disclosed WILL include sensitive information such as evaluation, habilitation/treatment information for mental health, developmental disabilities, alcohol or substance use/abuse or HIV/AIDs. **CHECK BELOW FOR EXCLUSION ONLY.**
☐ Alcohol/Substance Abuse ☐ Mental Health ☐ Developmental Disabilities ☐ HIV/AID's
☐ Other (specify)

(9) I understand that the above-named agency/facility/person authorized to receive this information has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider/ plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Regulations.

(10) I understand that I may revoke this authorization; however, the revocation must be in writing and must be sent/given to the facility record's department. I understand that no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

(11) Refusal to sign this form will result in the following consequences: INFORMATION WILL NOT BE DISCLOSED/OBTAINED.

(12) _____ _____
Signature of individual (age 12 or older) Date/Time

(13) _____ _____
Signature of parent/guardian (Under 18 or Disabled) Date/Time

(14) _____ _____
Witness OR (2nd parent/guardian, if co-custodial, may sign here) Date/Time

(15) _____ _____
Signature of staff person disclosing/obtaining information Date/Time:

DR. LAURA JANSONS
NEUROSCIENCE AND PSYCHOLOGICAL SERVICES

NEW PATIENT NFORMATION			
Patient's Name Street Address City, State, Zip Code			Email Phone
Birth date	Age	Referred by	Marital Status (choose one) Choose One

Problem
What are your reasons for seeking testing?

PAST PSYCHIATRIC HISTORY	
Have you ever seen a psychiatrist, psychologist or therapist in the past? choose	If yes, who?
Were you ever prescribed a medication to help your mood, anxiety or thinking? Yes/No	If yes, what medication?
Have you ever been hospitalized in a psychiatric facility? choose	If yes, where and when?
Have you ever tried to take your life? choose	if yes, when and what did you attempt to do?
Do you have medical problems? choose	If so, please list them:
Please list the medications you currently take:	Have you ever seriously hit your head or lost consciousness? choose

SUBSTANCE USE HISTORY	
Do you use alcohol? choose	if yes, please answer the following questions:
	What type of alcohol do you drink?
	How many days per week?
	How many drinks per day?
	What is the most you've ever drank?
Do you use cannabis, or other recreational drugs? choose	If yes, please list the drugs, the frequency, duration and quantity of use.
Do you smoke cigarettes? choose	if yes, please list frequency, duration and quantity of use.

FAMILY HISTORY	
Does anyone in your family have psychiatric problems? choose	If so, who and what type?
Does anyone in your family have substance abuse problems? choose	If so, who and what type?

OTHER	
Have you been under a lot of stress lately? choose	If yes, please list what events have been stressful.
Are you currently employed? choose	If yes, where and what type of work do you do? Do you enjoy your work?

Do you have children? choose	IF yes, how many, how old (and what are their names)?
Have you ever suffered physical, emotional or sexual abuse? choose	If yes, please indicate which.
Have you ever been in trouble with the law? choose	If yes, please describe
Have you ever served in the armed forces? choose	If yes, what branch, when and for how long?
What is the highest level of education you have completed?	Describe yourself in school (examples: outgoing, withdrawn, dropped out, no problems):
What else is important for us to know about?	

Please check the following if they apply to you:

- ☐ Sad, blue or blah feelings
- ☐ Low energy
- ☐ Difficult concentration
- ☐ Low motivation
- ☐ Difficulty with memory
- ☐ Low self esteem
- ☐ Hopelessness
- ☐ Loss of control
- ☐ Waking up at night
- ☐ Sleeping too much
- ☐ Changes in mood for no reason
- ☐ Thoughts of not wanting to go on
- ☐ Thoughts of ending your life
- ☐ Plans to follow through on taking your life
- ☐ Change in sexual interest
- ☐ Feeling nervous
- ☐ Feeling restless
- ☐ Worrying a lot
- ☐ Difficulty controlling worry
- ☐ Low pep during the day
- ☐ Onset of nervousness for no expected reason
- ☐ Pounding heart or chest pains
- ☐ Shortness of breath
- ☐ Dizziness or unsteadiness
- ☐ Upset stomach when nervous
- ☐ Feeling of going out of your mind
- ☐ Feeling of impending doom
- ☐ Feeling like you might die
- ☐ Feelings like you are out of your body
- ☐ Feelings like things are not real

Have you ever:

- ☐ Seriously hurt someone else
- ☐ Heard a voice when no one was there
- ☐ Thought others might be out to hurt you
- ☐ Thought something which you were not sure was true or not
- ☐ Noticed a change in your personality
- ☐ Had weakness or numbness in any part of your body?
- ☐ Had new onset of headaches
- ☐ Felt like you have to do something over and over again for no reason
- ☐ Had a thought in your mind which you could not get out of your head
- ☐ Problems with respect or relationships
- ☐ Fears that seem to interfere with your life

Thank you. (Provide details below as needed)

DR. LAURA JANSONS
NEUROSCIENCE AND
PSYCHOLOGICAL SERVICES

355 W. Dundee Rd, Ste 210, Buffalo Grove, IL 60089
150 E. Hawthorn Pkwy, Vernon Hills, IL 60061
224-636-6333

OUTPATIENT SERVICES CONTRACT-CHILD PSYCHOTHERAPY

Welcome to the practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you hope to address. There are many different methods we may use to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, you will be offered some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working together. At the end of the evaluation, we will both have an initial sense if I am the right therapist for you and, if not, I will give you referrals to other practitioners whom I believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we agree to begin psychotherapy, I will usually schedule one session (one appointment hour of [45-60] minutes duration) per week, at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours] advance notice of cancellation. If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

My hourly fee is $200. If we meet more than the usual time, I will charge accordingly. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. I charge $200 per hour for professional

services I am asked or required to perform in relation to your legal matter. I also charge a copying fee of $2 per page for records requests.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when such services are requested.

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 of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If necessary, I am willing to call the insurance company on your behalf to obtain clarification.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Though a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will try to assist you in finding another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit, if you request it. ***You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.***

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by the insurance contract.

CONTACTING ME

I am often not immediately available by telephone. Though I am usually in my office between 9 AM and 5 PM, I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by Katie our office assistant who knows where to reach me. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

CONFIDENTIALITY MINORS

Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with Me

In the course of my treatment of your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child – not the parents/guardians nor any siblings or other family members of the child.
If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or

guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.

- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm and possibly the police.
- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing _____, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents

Although the laws of Illinois may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child

custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $200 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Child/Adolescent Patient:
By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor's Signature* _____ Date_____

Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. _____ _____

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment. _____ _____

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above.

_____ _____

Parent/Guardian Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

* For very young children, the child's signature is not necessary