Gayle Plessner, Ph.D
MFT 85032
32107 Lindero Canyon Road # 124
Westlake Village, CA 91361
(805) 914-9383
gplessner@gmail.com

INFORMED CONSENT FOR MINORS

This Agreement contains the terms and conditions for services to be provided by Gayle Plessner, Ph.D for the minor child(ren):

_____ Birthdate: _____

_____ Birthdate: _____

_____ Birthdate: _____

_____ Birthdate: _____

and is intended to provide [please print name of parent(s)/legal guardian(s)] :

_____

with important information regarding office practices, polices and procedures, and to clarify the terms of the professional therapeutic relationship between myself and your child. Please speak with me if you have questions or concerns regarding the contents of this agreement prior to signing it.

Policy Regarding Consent for the Treatment of a Minor Child

I generally require the consent of both parents when providing therapeutic services to a minor child. If any question exists regarding the authority of your child's representative/guardian to give consent for psychotherapy, I will require supporting legal documentation, such as a custody order, prior to the onset of therapy.

Risks and Benefits of Therapy

A minor patient will benefit most from psychotherapy when his/her parents, guardians or other caregivers are supportive of the therapeutic process. Psychotherapy is a process in which myself and patients, and sometimes other family members discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so patients can experience their lives more fully. Therapy provides an opportunity to better, and more deeply understand oneself, as well as treat any problems or difficulties patients may be experiencing. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. Such benefits may also require substantial effort on the part of patients, as well as the child's caregivers and/or family members, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. This discomfort may also extend to other family members, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which I will challenge the perceptions and assumptions of patients or other family members, and offer different perspectives. Issues presented by patients may result in unintended outcomes, including changes in personal relationships.

During the therapeutic process, many patients find that they feel worse before they feel better. *This is generally a normal course of events.* Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Please address any concerns about treatment progress with me.

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice and at times, I may participate in clinical, ethical, and legal consultations with appropriate professionals. During such consultations, patients and their caregivers/guardians personal identifying information will not be disclosed.

Records and Record Keeping

I may take notes during session, and will also produce other notes and records regarding a patient's treatment. These notes are clinical and business records, which by California law are required and the sole property of this office. I will not alter normal record keeping processes at the request of any patient or representative. Should the patient or caregiver/guardian request a copy of my records; such a request must be made in writing. I reserve the right, under California law, to provide the patient or caregiver/guardian with a treatment summary in lieu of actual records. I may refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Caregivers/guardians will generally have the right to access the records regarding the patient, but this right is subject to certain exceptions set forth in California law. Should there ensue a request of my records, the request will be responded to in accordance with California law.

I maintain records for ten years following termination of therapy, or when the patient is 21 years of age, whichever is longer. However, after ten years, records will be destroyed in a manner that preserves confidentiality.

Confidentiality

The information disclosed by patients is generally confidential and will not be released to any third party without written authorization from the patient, except where required or permitted by law. ***Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.***

Please be aware that I am not a conduit of information between caregivers/guardians and patients. Psychotherapy can only be effective if there is a trusting, confidential relationship between the patient and myself. Although caregivers/guardians can expect to be kept up to date as to the patient's progress in therapy, typically detailed discussions between the patient and myself are not discussed. However, in the event of any serious concerns, caregivers/guardians will be informed regarding the safety or well-

being of the patient, including issues regarding suicidality. **Please be aware that overt life-threatening behaviors due to extreme drug and/or alcohol use will be considered as a danger to self, and in extreme cases, suicidal.

Patient Litigation

I will not voluntarily participate in any litigation, or custody dispute in which the patient, or caregivers/guardians/ other individuals, or entities, are parties. I do not communicate with attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in the patient's or caregiver's/guardian's legal matters. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving the patient, caregiver/guardian agrees to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate of $150.00/ session. In addition, I will not make any recommendations as to custody or visitation regarding the patient. I will make every effort to be uninvolved in any custody dispute between the patient's parents.

Psychotherapist-Patient Privilege

The information disclosed by the patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between the patient and myself in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-patient privilege on the patient's behalf until instructed, in writing, to do otherwise by a person with the authority to waive the privilege on the patient's behalf. When a patient is a minor child, the holder of the psychotherapist-patient privilege is either the minor, a court appointed guardian, or minor's counsel. Parents typically do not have the authority to waive the psychotherapist-patient privilege for their minor children, unless given such authority by a court of law. Caregivers/guardians are encouraged to discuss any concerns regarding the psychotherapist-patient privilege with his/her attorney.

The patient, or caregiver/guardian should be aware that the psychotherapist- patient privilege may be waived if one's mental or emotional state is made to be an issue in a legal proceeding. The patient or caregiver/guardian should address any concerns regarding the psychotherapist-patient privilege with his/her attorney.

Fee and Fee Arrangements

The fee for individual therapy is $150.00 for a 45-minute session. Family sessions and parent conferences are $175.00 for a 60-minute session. I maintain a limited number of appointment times for patients needing a reduced fee. Sliding scale fees are determined upon appointment availability, income and means to pay. ***Sliding scale fees will be reviewed regularly with periodic increases.***

An active credit card must be kept on file, however I accept payment by cash or check at the *beginning* of each session. Please make checks payable to Dr. Gayle Plessner. There is an ATM located in this complex, *so please come to session prepared to pay for your session. I do request a credit card number to be kept on file, should you miss an appointment without cancelling, or forget to bring payment at the time of session. Credit card information is securely stored in your confidential file along with your signed payment authorization form located in this packet.*

NOTICE TO ALL PATIENTS: I do not allow payment balances to exceed two weeks unless prior agreements have been established.

At times, we may engage in telephone contact for purposes other than scheduling sessions. Telephone calls longer than 15 minutes may incur therapy fees. If telephone contact with third parties is necessary, upon your written and authorized request you will be responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than 15 minutes.

Insurance

I am not a contracted provider with any insurance company or managed care organization, however I can provide a statement that can be submitted to a third-party to seek reimbursement of fees already paid.

Cancellation Policy

Your session time is protected for you and will remain so until notified otherwise. Caregiver/guardian is responsible for payment of the agreed upon fee for any missed session(s) not cancelled with at least 24 hours notice. Cancellation notices should be left on my voice mail at **805-914-9383.**

Therapist Availability

My office is equipped with confidential voice mail for messages to be left at any time. I will make every effort to return calls within 24 hours (or by the next business day. I am unable to provide 24-hour crisis service. **In the event that the patient is feeling unsafe or requires immediate medical or psychiatric assistance, the patient or caregiver/guardian should call 911, or go to the nearest emergency room.**

Termination of Therapy

I reserve the right to terminate therapy at my discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, the patient's needs are outside of my scope of competence or practice, or the patient is not making adequate progress in therapy. The patient or caregiver/guardian have the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, I will generally recommend that the patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and an opportunity to reflect on the work that has been done. I will attempt to ensure a smooth transition to another therapist by offering referrals if appropriate.

Pick Up and Drop Off

Children under 12 years of age are required to be escorted into the office, and caregivers/guardians are required to remain in the lobby or in the office complex.

During evening hours when it is dark outside, your child will not be allowed to leave the office alone under any circumstances.

**Please remember that sessions for children are 45 minutes; please be back in the lobby or waiting directly outside the office prior to session's end. **

Thank you for your cooperation on this matter!

Acknowledgement and Signatures

By signing below, caregiver/guardian acknowledges that he/she has reviewed and fully understands the terms and conditions of this agreement, and has discussed any questions and concerns with me. Caregiver/guardian agrees to the terms and conditions of this agreement, consents to participate in psychotherapy with Gayle Plessner, Ph.D and agrees to hold me free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____

Patient Name (please print)

_____ _____

Signature of Patient (if Patient is 12 or older) Date

_____ _____

Signature of Caregiver/guardian, relationship to Patient Date

_____ _____

Signature of Caregiver/guardian, relationship to Patient Date

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

Name(s) of Responsible Party (Please print)_____

_____

Signature(s) of Responsible Party:

_____ Date: _____

_____ Date: _____

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Information for Minor Child

Referred by: _____

Name of Patient: _____

Address: _____

City, State, ZIP: _____

Patient's DOB: _____

Pediatrician Name: _____

Pediatrician Phone: (____)_____-_____

Parent Name: _____

Home PH: (____)_____-_____ Cell: (____)_____-_____ Wk: (____)_____-_____

Parent Name: _____

Home PH: (____)_____-_____ Cell: (____)_____-_____ Wk: (____)_____-_____

Email: _____

Parents are: ___Married ___Unmarried ___*Divorced ___Separated ___ Widowed

Child resides with _____

* Legal Custody documents must be on file with Therapist

Other person(s) residing in Home (siblings, ext. family members, others):

_____ Age: _____ Relationship: _____

_____ Age: _____ Relationship: _____

_____ Age: _____ Relationship: _____

_____ Age: _____ Relationship: _____

Child's Medication(s), dosage: _____

_____

_____

Prescriber's Name: _____

Prescriber's Phone: _____

Prescriber's Address: _____

Child's School: _____

School Phone: _____

Person responsible for payment (Please Print):

_____

DL# and state: _____

Address (if different from above):

_____

City: _____ State: _____ ZIP: _____

Emergency Contact (Please Print Clearly):

_____

Emergency Phone : (___)____-_____

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Authorization to Exchange Confidential Information

I, [Name of Patient] _____
authorize Gayle Plessner, Ph.D to exchange confidential information regarding my treatment with [name and function of person to which information is to be exchanged]

_____

This Authorization permits the exchange of the following information:

____ Any and All Information Necessary

____ Diagnosis ____ Progress to Date ____ Patient Records ____

____ Treatment Plan ____ Prognosis ____ Clinical Test Results ____

Information limited to: _____

This Authorization shall remain valid until: _____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing

_____ _____

(Patient or Patient's Representative*) Date

*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative

Credit Card Authorization Form

I understand that this authorization is valid until canceled in writing. I understand this information is secured in a locked, protected patient file. I agree to assume the risk in the unlikely event this file and/or account is tampered with and credit card information is compromised. **I understand that charges for missed sessions not cancelled within the agreed upon 24-hour cancellation period or non-payment at time of session** *will be posted to my credit/debit account within 48 hours of each session date and* ***session fee will be charged on the day of my session.*** Additionally, I agree that the card listed below may be charged by my therapist in order to settle outstanding balances. I am responsible for charge back fees or retrieval fees.

Initial _____

I agree that if I have any concerns or questions regarding charges to my account, or if charge fails to post to my account, I will contact my therapist for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with my therapist and those attempts have failed.

Initial _____

If I am assuming responsibility for session payment of a Patient other than myself, I understand that *I am not entitled to information pertaining to confidential therapy sessions* as provided by Gayle Plessner, Ph.D.

Initial _____

My signature confirms that I understand and agree to these terms, understand the conditions of this payment policy and agree to the conditions stated above:

Cardholder Name [print]: _____

Signature _____

Relationship to Patient: _____

Credit Card Billing Address: _____

City: _____ State: _____ ZIP CODE: _____

Card Type: _____

Acct. Number: _____

Security Code: _____ Exp. Date: _____

I understand that my therapy sessions will be charged via this form and not by swiping my card on the morning of my session.

_____ _____

Cardholder Signature **Date**