Information for Minor Clients and Policy of Informed Consent for Psychotherapy

Mount Olivet Counseling Service
5000 Logan Avenue South, Mpls, MN, 1804 West 50th St., Mpls, MN or
7150 Rolling Acres Road, Victoria, MN
Phone: 612-927-7335, Fax: 612-927-4259

A Ministry of Mount Olivet Lutheran Church

*Parents/Guardians: Please read the following information, and sign.

APPOINTMENTS AND SCHEDULING

Appointments may be made by calling 612-927-7335 and speaking with Anne, the Office Manager at extension 10. She can also be reached via email at annel@mtolivetcounseling.org. If you wish to leave a message for your therapist regarding other matters, you may do so at their extension directly. We are not a crisis center. Although therapists retrieve and respond to messages regularly, they do not consistently do so on weekends. If you are in crisis or believe a crisis may arise please call 911.

Sessions are 50 minutes long. If a client is late for their appointment, the appointment time will not be adjusted.

FEES

Fees for members of Mount Olivet are $40.00 per session for counseling services.
Fees for non-members are $80.00 per session.
We do not work with third party payers/insurance companies.

Please contact Anne 24 hours in advance of the scheduled appointment time, if you need to cancel. **A no-show, or a cancellation later than 24 hours prior to the scheduled appointment will be charged the session fee.** We reserve the right to decline scheduling of future appointments if there is a pattern of cancellations or no-shows.

We do not send out monthly bills or keep record of payments. You are asked to pay for each session as it occurs unless you make other arrangements, and to ask for a receipt if you believe you will need one. If you are unable to pay the full fee please ask Anne for an Application for Financial Assistance on which you can indicate the amount you are able to pay, with a minimum payment of $10.00 per session.

CLIENT BILL OF RIGHTS AND RESPONSIBILITIES

The purpose of this policy is to ensure that the human rights and civil liberties of all clients are safeguarded. Therapists who work with children and families deal with individuals and groups of individuals in interrelationship. Therefore all rights and responsibilities that pertain to clients must be considered in terms of individual as well as familial needs. Please read this with careful consideration so we can discuss any questions that may arise.

I. CLIENT RIGHTS

Each client has the right to receive the best care possible without violation of rights.
Client rights shall include the following:

1) To expect that a therapist has met the minimal qualifications of training and experience required by the law.

2) The right to considerate, appropriate and professional treatment.

3) The right to respect and privacy in regard to your therapy program. Case consultation is handled without revealing the client's name or other identifying details.

4) In order to ensure the best possible care, the interns & professional staff meet weekly to consult and collaborate regarding client care;

5) To be informed of the cost of professional services before receiving the services.

6) The right to freely discuss your needs and wants, to present suggestions and complaints and to be part of decision-making about your treatment plans and to refuse treatment.

7) To have access to their records as provided in subpart 1a and Minnesota Statutes, section 144.335, subdivision 2.

8) To examine public records maintained by the Board of Marriage and Family Therapy which contain the credentials of a professional; 2829 University Avenue West, Suite 330, St. Paul, MN 55114. Phone: 651-617-2220.

9) To obtain a copy of the Rules of Conduct from the State Register and Public Documents Division, Department of Administration, 117 University Avenue, St. Paul, MN 55155.

10) To report complaints to the Board of Marriage and Family Therapy, 2829 University Avenue West, Suite 330, St. Paul, MN 55114. Phone: 651-617-2220.

11) To privacy regarding information contained in the case record. No information will be released outside the office without your informed, written consent except for the following instances:

    a. Your records are court ordered.
    b. In the case of suspicion of child abuse or neglect or vulnerable adult abuse or neglect.
    c. If you are pregnant and you are suspected of using controlled substances (such as street drugs) for non-medical purposes, I am required to report this to authorities.

    d. You are a minor (under age 18), in which case your parents have access to your records. You might be able to request that they not have access.
    e. In case of an emergency or if you threaten to seriously harm yourself or another, I may have to break confidentiality and summon additional help.
    f. In case of a threat to seriously harm another I have a legal obligation to warn the intended victim.
    g. If an insurance company or another third party is paying for my services, that party may have the right to review your records.
    h. If you disclose misconduct by a licensed health care professional and tell me that person's name, state law requires me to report that to the licensing board. Your name would be included in that report.

The client will be advised if any release of information occurs. For couples or family counseling we maintain only one record with information about both or all of you. Therefore release of information from your record requires consent of all adults and any minors with capacity to consent.

12) To be free from being the object of discrimination on the basis of race, religion, gender or other unlawful category while receiving psychological services.

13) To be free from exploitation for the benefit or advantage of the psychologist or Marriage and Family Therapist.

II. CLIENT RESPONSIBILITIES

Each client has the responsibility to:

1) Refrain from abuse of self, others and property.

2) Devote reasonable energy and time to following the treatment plan, which we've created together.

3) Be honest, open and willing to share your concerns.

4) Keep appointments as made. If you need to cancel please give 24-hour notice if possible.

5) Keep current in paying fees.

6) Respect confidentiality of others you may encounter waiting for an appointment or exiting and entering the building.

E-MAIL AND SOCIAL NETWORKING POLICIES

Please do not email your therapist information related to your therapy sessions, since email is not completely secure or confidential. If you send an email, we will not respond by email. Be aware that all emails are retained in the logs of your and our Internet service providers. While it may be unlikely that someone reads these, they are available to be read by the system administrator of the Internet Service Provider. You should also know that any e-mails received from you become a part of your legal and therapy records. Please do not use texting, Twitter, Facebook, LinkedIn or other forms of social media to contact the therapist. These sites are not secure. We do not accept friend requests or contact requests from current or former clients on any social networking site, since adding clients as friends or contacts can compromise your confidentiality and privacy. It may blur the boundaries of our therapeutic relationship.

THE RELATIONSHIP OF THERAPIST AND CLIENT

The client/counselor relationship is different from other relationships you may have with a physician, pastor or coach. The boundaries of a therapeutic relationship mean that it is inappropriate for a client and a counselor to spend time together socially, to bestow gifts, or to attend family or religious functions. If you and your therapist encounter each other in the community, the therapist may nod or smile, but will not acknowledge you as anyone he/she knows. The therapist is not being rude, but attempting to maintain your confidentiality. Even though you might invite the therapist, he/she will not attend family gatherings, such as parties or weddings, and will not give you gifts. Please refrain from giving gifts to the therapist. The purpose of these boundaries is to make sure that we are clear in our roles for your treatment and that your confidentiality is maintained.

MINORS AND THERAPY AGREEMENT

Minors and confidentiality: If you are a minor, you have a limited right to privacy in that your parents may have access to your records. However, minor clients have rights to complete confidentiality in obtaining counseling for pregnancy and associated conditions, sexually transmitted diseases, and information about drug and alcohol abuse. If the therapist believes that sharing this information will be harmful to you, confidentiality will be maintained to the limits of the law.

Parents, if the child prefers not to volunteer information about the sessions, please respect his/her right to not disclose details. *Unless the child is in clear danger to self or others, or has been abused*, the therapist will normally tell you only the following: whether sessions are attended, whether or not your child is generally participating, and whether or not progress is generally being made. Mental health records are kept confidential to protect the child's ability to speak freely about their relationships and concerns, and it is rarely in the child's best interest to have therapy records read by parents. Parents are encouraged to communicate regularly with their child's therapist. For unattended minors, it is asked that voicemails be left for the therapist prior to the child's session with parents' concerns or issues helpful to therapy process.

Payment for Minors: Parents or guardians accompanying minors are responsible for payments or balances *at the time of service*. If a minor is accompanied by an adult other than a parent or guardian, payment is still expected at the time of service. For unaccompanied minors, charges must be paid to the office by cash or check prior to or at the time of service.

FOR PARENTS WHO ARE DIVORCED AND/OR NOT LIVING TOGETHER:

Minors and Shared Custody: Children have ongoing developmental needs for regular contact with both parents, unless it can be shown that this contact threatens the child's safety or mental health. We will attempt to involve both parents in the child's care except in cases of abuse or serious impairment on the part of one or both parents, or when the involvement would be detrimental to the child's mental health or would interfere with the child's treatment. We welcome involvement of noncustodial parents, step-parents, siblings, grandparents and others, but participation in therapy is determined based on the child's needs, and the child's and parents' wishes. At the onset of therapy, each parent is requested to read suggested material regarding co-parenting.

Authorization for therapy: In cases where there is ***joint legal*** custody between parents or guardians who are not married or cohabitating, **we require both parents' authorization and signature for treatment of their minor child/ren, prior to the child being seen.** In cases where one parent has ***sole legal*** custody of their minor child/ren, only that parent is required to authorize treatment.

Neutral, helping role: Because the role is that of the child's helper, the therapist will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. *Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist.* However, you should be aware, if you should become involved in a legal matter and the therapist is subpoenaed to court, you will be charged any and all applicable legal fees. Our goal is neutrality; we ask that **neither parent assume bias** or that we take sides between parents in conflict. Our goal is that of working toward more peaceful functioning of the entire family system of the child. If this process becomes too conflictual, we reserve the right to discontinue therapy services. In these situations, co-parenting mediation services may be more appropriate.

Communication: Each parent is encouraged to let the therapist know of any difficulties/concerns/ observations they may have, **regarding the child**, (rather than issues re each other,) before any appointment either parent may schedule. The issues will then be addressed with both parents, in an attempt to remain fair and balanced, and woven into the therapy session with the child. Parents should understand that telephone, face-to-face, email or written communication from either parent will become part of the child's permanent

record. As therapy progresses, each parent will be communicated with via an email regarding feedback from the sessions, or if the therapist feels it is necessary.

Scheduling appointments: Either legal guardian/parent may schedule an appointment for their child, and may determine who attends the appointment they schedule. If there is a communication problem resulting in a missed appointment**, the person who scheduled the appointment is responsible for payment** of the missed appointment fee. We expect *parents to inform each other* about scheduled appointments. Nor is it our responsibility to inform either parent of the other's scheduling activity. Each parent is welcome to schedule appointments for **parenting/co-parenting support** for themselves separately as well. *The expectation is that parents will work toward communicating with each other openly regarding therapy, being the best parents they themselves can be, and that each parent will cultivate a healthy relationship and open communication with their child.*

INFORMED CONSENT FOR EVALUATION AND TREATMENT

MOUNT OLIVET COUNSELING SERVICES

I acknowledge that I have discussed and received a copy of the handout: "INFORMATION FOR CLIENTS AND POLICY OF INFORMED CONSENT FOR PSYCHOTHERAPY," and that I enter into therapy in agreement with this policy. **(All legal guardians of the minor child must consent to therapy for that child.)**

Signed _____ Date _____

(Client/Parent/Guardian)

Signed _____ Date _____

(Client/Parent/Guardian)

Signed _____ Date _____

(Client/Parent/Guardian)

Consent to Treatment of a Minor

I, _____ ,

_____ ,

(Please print name/s of Parent or Guardian)

agree to allow my child(ren),

_____ ,

_____ ,

_____ ,

(Please print name(s) of child(ren))

to receive counseling from Shannon Himango, MA, LMFT, Sara Watne MA, LPCC or Jessica Smith, MA, LMFT.

Signed _____ Date _____

(Parent or Guardian)

Signed _____ Date _____

(Parent or Guardian)

Payment Agreement

I agree to pay for each session at the time of session. I will provide notification to the Counseling office prior to 24 hours before the scheduled appointment time if I need to cancel my appointment.

I understand that a **no-show, or a cancellation later than 24 hours prior to the scheduled appointment will result in my being charged the session fee.**

Signed _____ Date _____

(Parent or Guardian)

Signed _____ Date _____

(Parent or Guardian)

FAMILY AND MEDICAL HISTORY –Youth/ Family

CHILD'S PRESENT FAMILY

	Name	Date of Birth	Age	Occupation
Parent/s or Adults Involved:	_____	_____	____	_____
	_____	_____	____	_____

Do all legal guardians approve of therapy for the child? Yes _____ No _____

	Name	Date of Birth	Age	Grade/School Name
Stepparents, Or Co-parents if applic:	_____	_____	____	_____
	_____	_____	____	_____
Minor Client/s	_____	_____	____	_____
Other Children/siblings If Applic:	_____	_____	____	_____
	_____	_____	____	_____

ADDRESS: _____City: _____State: ____ Zip:_____

PHONE #s: Name: _____ #_____Ok msg?__

Name: _____ #_____Ok msg?___

Name: _____ #_____Ok msg?___

Email/s: _____ _____

Emergency Contact:_____ Phone# _____

For parent/s, list dates (if applicable) of:

Parent: _____ Marriage_____ Separation _____ Divorce/Widow _____Remar/Dating_____

Parent: _____Marriage_____ Separation _____ Divorce/Widow _____Remar/Dating_____

MEDICAL

Please list any **medications** child is taking.	How long?	Reason?
_____	_____	_____
_____	_____	_____

Date (approx.) of child's last **physician's** visit:_____

Please list any current or chronic **health or mental health** issues for child:_____

_____

Please list any other therapeutic or support **services involved** with child or family:_____

_____

Does Child have an IEP at school? IF so**, please describe**:_____

Please list **legal/physical custody** arrangements, and **parenting time structure**, for children involved, if applicable:_____

PARENT/GUARDIAN ASSESSMENT

Date:_____

Name of child: _____ Age: ___ Birth Date: _____
Name/s of parent/s or guardian/s completing form:_____ _____

Do all legal guardians approve of therapy for the child? (Required.) Yes _____ No _____

1. Parents/Guardians: Please list your child's **strengths/areas that are going well**:

2. Please check your top priority concerns for your child below, and a provide a brief description:

Concerns (check those that apply.)	**Describe: For how long, how often, triggers, etc**.
___Depression, irritability, sad mood, Low self esteem, loss of interest/pleasure.	_____
___Suicide thoughts, intent, plans, or comments.	_____
___Self-injurious behavior.	_____
___Anxiety, excessive worries, separation fears.	_____
___Hearing voices-when there was no one there—speaking about them or telling them what to do or saying bad things to them.	_____
___Saying that they had intrusive/obsessive thoughts?	_____
___Repetitive behaviors or mental acts in response to intrusive/ obsessive thoughts:	_____
___Feeling the need to check on certain things over and over again, like whether a door was locked.	_____
___Worrying a lot about things touched being dirty or having germ?	_____
___Started more projects than usual, or did more Risky things than usual?	_____
___Slept less than usual, but still had lots of energy?	_____

Concerns (check those that apply.) **Describe: For how long, how often, triggers, etc.**

___Difficulty identifying and expressing feelings. _____

___School/homework problems. _____

___School refusal/skips class. _____

___Attention issues in school, difficulty staying seated, waiting turn, blurting out answers, easily distracted, interrupts/intrudes. _____

___Family problems (impacted by.) _____ _____

___Defiance/arguing with parents. _____
___Defiance/arguing with teachers. _____
___Frequent temper tantrums. _____

___Drugs/alcohol/vaping/cigarettes or other chemical use. _____

___Used any medicine without a doctor's Prescription? _____

___Losing control of anger and acting out aggressively. _____

___Cruel to others and/or bullying _____

___Cruel to animals. _____

___Stealing _____

___Running away _____

___Stealing or destruction of property _____

___Issues with food/eating Problems maintaining weight?_____Intense fear of weight gain?_____Binge eating?_____Purging?____

_____

___Not accepting responsibility for his/her own actions. _____

___Sleeping problems _____

Concerns (check those that apply.) **Describe: For how long, how often, triggers, etc.**

___Social skills; making and keeping friends. _____

___Being bullied/taken advantage of by others. _____

___Abuse (physical, sexual or emotional) of child by other/s: _____

___Recent changes in behavior, health or personality _____

How long have the checked issues been of concern? _____

Family History:

___Family history of depression. Child's: ____father ____mother _____grandparents

___Family history of anxiety. Child's: ____father ____mother _____grandparents

___Family history of substance abuse. Child's ____father ____mother _____grandparents

___Other mental health issues_____ _____father ____mother _____grandparents
_____ _____father ____mother _____grandparents

___Medical issues for child? Surgeries/accidents?_____ _____

Medication/s?_____Date of last physician check up?_____

___Birth story / developmental complications? _____
_____

Student's general weekly AFTER SCHOOL routine / homework/ activities / interests:

Mon._____
Tues. _____
Wed. _____
Thurs. _____
Fri. _____
Weekend: _____
_____
_____

Has child participated in counseling/ therapy services before? __Yes __No. If yes, please list
Date: _____ Reasons:_____
_____ _____

Main reason for seeking therapy for child at this time: _____
_____