

**Information and Intake Forms for Parents of Minor Clients and  
Policy of Informed Consent for Psychotherapy  
Mount Olivet Counseling Service**

5000 Logan Avenue South, Mpls, MN, 1804 West 50<sup>th</sup> St., Mpls, MN or  
7150 Rolling Acres Road, Victoria, MN  
Phone: 612-927-7335, Fax: 612-927-4259

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

**APPOINTMENTS AND SCHEDULING**

Appointments may be made by calling 612-927-7335 and speaking with Molly, our Office Manager at extension 10. She can also be reached via email at [mpach@mtolivetcounseling.org](mailto:mpach@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 \$50.00 per session for counseling services.

Fees for non-members are \$100.00 per session.

We do not work with third party payers/insurance companies.

Please contact Molly 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 Molly 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 \_\_\_\_\_  
(Client/Parent/Guardian)

Date \_\_\_\_\_

Signed \_\_\_\_\_  
(Client/Parent/Guardian)

Date \_\_\_\_\_

Signed \_\_\_\_\_  
(Client/Parent/Guardian)

Date \_\_\_\_\_

### 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 Sherri Dunham, MA, LPCC.

Signed \_\_\_\_\_  
(Parent or Guardian)

Date \_\_\_\_\_

Signed \_\_\_\_\_  
(Parent or Guardian)

Date \_\_\_\_\_

### 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 \_\_\_\_\_  
(Parent or Guardian)

Date \_\_\_\_\_

Signed \_\_\_\_\_  
(Parent or Guardian)

Date \_\_\_\_\_

**FAMILY AND MEDICAL HISTORY –Youth/ Family  
CHILD’S PRESENT FAMILY**

<u>Name</u>	<u>Date of Birth</u>	<u>Age</u>	<u>Occupation</u>
Parent/s or _____ Adults	_____	_____	_____
Involved: _____	_____	_____	_____
<b>Do all legal guardians approve of therapy for the child?</b> Yes _____ No _____			
Stepparents, _____ Or Co-parents	_____	_____	_____
if applicable: _____	_____	_____	_____
<u>Name</u>	<u>Date of Birth</u>	<u>Age</u>	<u>Grade/School Name</u>
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 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:** \_\_\_\_\_  
\_\_\_\_\_