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Parental Consent for Services
For Parents of Adolescent Clients Ages 13-17

This document contains information about my professional services and business practices. Please print out this form, read it carefully, sign it, and return it to me at your child's first appointment. Be sure to write down any questions you may have so that we may discuss them when we meet. Your signature on this form represents an agreement between us.

Background and Credentials

I am a Florida Licensed Psychologist (License #PY 8082). My educational background includes a B.A. in Psychology from Smith College, an M.A. in Psychology from American University, and a Ph.D. in Clinical Psychology from American University. My graduate work included training and supervised experience in various types of therapy, including cognitive-behavioral therapy, psychodynamic therapy, humanistic therapy, and family-based treatment for adolescent eating disorders. I completed my pre-doctoral internship at the University of Miami Counseling Center, including a rotation with the Miami-Dade County Department of Human Services – Psychological Services Division.

I opened my private practice in 2009 and completed my post-doctoral residency in supervised private practice from 2009 - 2010. Since 2010, I have been working independently in private practice. I have taken professional courses and workshops on Dialectical Behavior Therapy (DBT), Acceptance and Commitment Therapy (ACT), and Mindfulness-Based Stress Reduction (MBSR). I typically work with pre-teens, adolescents, and college students (ages 9-25). My areas of expertise include eating disorders, anxiety disorders, body dysmorphic disorder, self-injury, and depression. In addition to my clinical work, I write articles on mental health for a number of different websites, and I serve as a professional advisor for FEAST: Families Empowered and Supporting Treatment for Eating Disorders, a global non-profit organization which provides information and support to parents and loved ones of eating disorder patients.

Psychological Services

Our first session, which will last for approximately 2 hours, will involve an evaluation of your child's history and presenting concerns. I require that you, your child, and your spouse or partner (if applicable) be present at this first session. By the end of the initial session, I will share my general impressions with you and your child, and we will discuss a treatment plan that best suits your child's needs as well as your family's needs. If we decide that I am not the best therapist for your child, or that your child needs a different level of care, then I will provide you with referrals to other professionals or treatment centers which may be a better fit for your child.

After the initial evaluation, psychotherapy sessions are typically scheduled once per week, with each session lasting for 50 minutes. However, for adolescents with more severe difficulties, I may recommend two or three sessions per week. During the course of our work together, we may decide to increase or decrease the frequency of sessions based on the progress your child makes.

Your child is expected to arrive on time and attend all scheduled appointments. If your child is running late for an appointment or needs to cancel or reschedule, please notify me as soon as possible.

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Approach to Treatment

My approach to psychotherapy is individualized, collaborative, and evidence-based. The specific treatment approach we decide to use will be based on a variety of factors, including your child's age, diagnosis, personality, and family situation as well as the nature and severity of his or her difficulties. I believe that parents are a child's greatest resource in recovery. Your child is likely to have the best possible outcome when you and I communicate openly and work collaboratively to help your child thrive.

My treatment techniques are derived from Cognitive-Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Acceptance and Commitment Therapy (ACT), Mindfulness-Based Stress Reduction (MBSR), and the Maudsley Method of Family-Based Treatment (FBT) for eating disorders. These treatment methods are empirically-supported, which means that scientific research has demonstrated that these methods are particularly effective for treating certain problems. Please feel free to ask me if you have any questions or concerns about the treatment approach I recommend.

Family Involvement in Treatment

Your child's treatment is most likely to be successful if you are fully informed and actively involved. At the start of your child's treatment, I will provide you with information and reading materials about your child's problem(s) and the treatment approach we are using so that you will be fully informed.

The degree of your involvement with your child's treatment will be based on his/her age, your family situation, your family's preferences, and the nature and severity of your child's problems. We may decide that an individual treatment approach would best suit your child's needs. In this case, I would meet with your child for one-on-one sessions on a weekly basis, or more frequently if necessary.

Over the course of treatment, I will contact you periodically with updates on your child's progress. You and I can discuss how frequently these updates will occur and what information will be communicated. For example, in some cases, I send an email update to parents after each session. In other cases, these updates may occur once or twice a month, or as needed. I may also begin a dialogue with you about how you can help your child at home.

You are welcome to email me or call me at any time during the course of your child's treatment to ask questions or to share information about your child. In addition, you are always welcome to schedule an appointment to meet with me privately, or with your spouse or partner, without your child present. We may decide to have you participate in some sessions with your child.

Therapy is most effective in the context of a trusting, supportive, confidential therapist-client relationship. It is important for adolescents to discuss their problems and concerns with a neutral party without fear of judgment or repercussions. Thus, the specific information your child discusses with me during individual sessions will remain private between the two of us. However, there are exceptions to this rule. If your child reveals information suggesting a threat to his or her life, health, or safety, or a threat to the life, health, or safety of another person, I will inform you promptly and we will work together to deal with the issue at hand.

We may decide that a family-based approach will best suit your child's needs. I typically use a family-based treatment (FBT) approach to treat children and adolescents with eating disorders because research has demonstrated that it is more effective than individual therapy for this population. In this case, I will meet with your family on a weekly basis. Depending on your family's situation, it may not be necessary for both parents to attend all sessions. Siblings and other family members may be involved in your child's treatment to some degree if we determine that it may be beneficial.

Fees

Payment is due at the time of service. I accept cash, checks, and major credit cards including Visa, MasterCard, and Discover. My standard fee is $250 per hour. I charge $500 for the initial evaluation, which generally lasts two hours. Subsequent sessions are generally 50 minutes and cost $250. I do not charge for phone calls, paperwork, emails, consultation / communication with other healthcare providers, or preparation time.

I offer reduced rates for college and graduate students and other individuals based on financial situation. If you believe that you may be eligible for my reduced rate, please discuss this with me at the start of your child's treatment. I am open and flexible with regards to finances and I am more than willing to negotiate a fee schedule and payment plan that allows your child and family to access high-quality treatment of the frequency and duration needed to achieve full and lasting recovery.

Once you have scheduled an appointment, you will be expected to pay for it unless you provide 24-hours advance notice of cancellation. **You will be charged for no-shows and for appointments cancelled with less than 24-hours notice.**

To save time and eliminate the hassle of weekly payment, I strongly encourage clients to complete an **Electronic Payment Authorization form**. You can download and print out this form from the "forms" section of my website, or I can give you a hard copy of the form during our first meeting. This form allows me to deduct your session fee (including fees for no-shows and late cancellations) from the credit card or debit card designated on this form. This information will be stored securely in your clinical file and may be updated upon request at any time.

I do not take insurance. I will provide you with a monthly statement upon request which you may submit to your insurance company. Many insurance companies provide some reimbursement for mental health services, and I am willing to complete the necessary paperwork for you to receive any mental health benefits to which you are entitled. However, you are responsible for paying me for your sessions regardless of what your insurance company decides, and I cannot guarantee that you will be reimbursed. If you wish to be reimbursed, it is important that you discuss these issues with your insurance company prior your first appointment.

Confidentiality

Confidentiality is a cornerstone of the therapist-client relationship. The ethical standards of my profession require that my work with you and your child remains confidential. This means that I cannot reveal any information about you, your child, or your family, either verbally or in writing, to anyone else

without your written permission. In general, the privacy of all written and oral communications between a therapist and client is protected by law.

There are a few exceptions to confidentiality which are summarized below.

- Child Abuse or Elder Abuse. I am mandated by law to report cases of suspected child abuse (of children and youth under age 18) and elder abuse (of adults over age 60) to the appropriate authorities. The purpose of the mandated reporting laws is to protect the public from predators, who tend to be repeat offenders.
- Suicide. If your child is in imminent danger of killing himself or herself, I will need to breach confidentiality in order to keep him or her safe. This may include informing family member(s) or taking action to see that he or she is admitted to a hospital.
- Homicide. If your child discloses to me that he or she is planning to kill someone, I am required by law to inform the police, inform the intended victim(s), and inform any other necessary individuals in order to prevent loss of life.
- As mandated by law. For example, if I receive a subpoena, I may be required to submit your child's records as part of a legal proceeding.

These situations are relatively rare. If a similar situation occurs in your child's case, I will make every effort to discuss it fully with you and with your child before taking any action.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections and client rights with regard to the use and disclosure of your child's Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a notice of privacy practices for the use and disclosure of PHI for treatment, payment, and health care operations. The HIPAA notice is in a separate document, which is available on my website in the "forms" section. Please print out a copy of the HIPAA notice for your records. Alternatively, I can provide you with a copy of the notice at our first meeting.

Signature

Your signature below indicates that you have read this document and agree to abide by its terms during the course of your child's treatment. Your signature also serves as an acknowledgment that you have received the HIPPA notice described above.

_____ _____

Signature of Parent Date

_____ _____

Parent's Name (please print) Parent's Date of Birth

_____

Child's Name Child's Date of Birth