Meyer Therapeutics, PLLC
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Informed Consent for Treating Minors

This document is a supplemental Informed Consent Form to the "Informed Consent for Treatment" form. It contains important information about participating in psychotherapy with me if you are a minor or a family with minor children. Please read it carefully and ask any questions you may have. When you sign this document, it will represent an agreement between us.

PARENT/GUARDIAN AUTHORIZATION FOR MINOR'S MENTAL HEALTH TREATMENT

In order to authorize and initiate 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. If necessary, 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 and 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 therapy with your child 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/guardians 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 treatment with your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that at all times, my client 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 the 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.

DISCLOSURE OF MINOR'S TREATMENT INFORMATION TO PARENTS/GUARDIANS

Therapy is most effective when a trusting relationship exists between the therapist and the client. 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 they feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents/guardians. This is particularly true for adolescents who are naturally developing a greater sense of independency and autonomy.

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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 behaviors that you may not approve of or may be upset by, but that do not put your child at risk of serious or immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will 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/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/GUARDIANS

Although the laws of Arizona 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 and their parents/guardians, 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). In the event that it is necessary for me to testify before any court, arbitrator, or other hearing officer to testify at a deposition or to present any or all records pertaining to the therapeutic relationship to a court official, the client agrees to pay me for my services. An initial $3,000 retainer is required to be paid in full 14 calendar days before testimony is scheduled or records are to be submitted to the court. Because of the difficulty of legal involvement, additional costs that are reimbursed to me at your expense include: travel time and travel expenses, meals, copies, parking, phone consultation, letter compilation, communication with my legal counsel, and record(s) review at the rate of $160 per hour, rounded to the nearest half hour. There is a minimum charge of eight (8) hours billed

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for each day that I am required to attend court, hearings, testimonies, and/or submit records to the court as all other clients will need to be cleared from my calendar for that day. The full day is billed to you even if the testimony, arbitration, hearing, or record submission is cancelled/postponed for that day or takes fewer than eight hours. Other letters and paperwork requested by the client will be assessed a charge of $160 per hour, rounded to the nearest hour, with a minimum 1-hour charge. This does include letters to court officials or attorneys, and any other documentation requested by the client. This does not include copies of your bill, missed work, or school letters, Release of Information Forms, nor any other documents used in the day-to-day operation of the office.

INFORMED CONSENT

As stated prior, this agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

CHILD/ADOLESCENT CLIENT

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 Name: _____

Minor's Signature: _____ Date: _____

PARENT/GUARDIAN OF MINOR CLIENT: 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.

_____ _____
Initials Initials

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.

_____ _____
Initials Initials

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.

_____ _____
Initials Initials

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Name of Parent/Guardian: _____

Parent/Guardian Signature: _____

Date: _____

Name of Parent/Guardian: _____

Parent/Guardian Signature: _____

Date: _____

_____ Date: _____
Lauren Meyer, PhD, LP, NCSP