Jennifer Hill, LPCC #2992
Licensed Professional Clinical Counselor
317 N El Camino Real 306 Encinitas, CA 92024
email: admin@jenniferhillcounseling.com
website: www.healingheartscounselingsd.com

INFORMED CONSENT FOR TREATMENT:

COUNSELING SERVICES FOR CHILDREN

Counseling: This is a collaborative process between the counselor, parent(s)/legal guardian(s), and the child(ren) working together on mutually agreed upon goals. Therapy can involve discussions that may be distressing for the child(ren) in treatment, however the design begins with a biopsychosocial evaluation, then identifying present concerns working to improve the child's self-image and develop positive change leading to more stable relationships with others. It may be necessary that parent(s)/legal guardian(s) participate in the counseling process with the their child(ren) at the discretion of the counselor.

Confidentiality: Information obtained during counseling sessions will not be disclosed to any outside persons or agencies without your written permission, except when required by law:

1. reasonable suspicion of abuse of children or elderly persons
2. client(s) present a serious danger of violence to another
3. client(s) may be harm to him/herself unless protective measures are taken

We understand that information discussed in therapy with our child is for therapeutic purposes and is not intended for use in any legal proceedings, therefore we agree not to subpoena Jennifer Hill to testify on the behalf of either parent in a court action. We have been given the opportunity to ask questions and discuss confidentiality policies with Jennifer Hill. If we have any further questions or concerns regarding expectations of confidentiality, we can contact our child's counselor at (760) 458-1600. _____ **(initial)**

Payment: We understand that as private paying clients, we are expected to pay at the time of counseling services by credit card, cash, or check. The standard fee is $150.00 per session, unless special arrangements have been approved. We agree to pay the agreed upon amount of $_____ for all services provided by Jennifer Hill at the end of each session. Any check returned for insufficient funds will be assessed a $35 fee. We understand that if we chose to pay with a credit card, then we must also pay 3.75% processing fee + 15 cents.

_____ **(initial)**

Insurance: It is recommended that you contact your insurance carrier to find out how much they pay for outpatient psychotherapy treatment. The amount of payment will depend on your policy. Many medical health insurance policies do cover at least part of the cost of outpatient psychotherapy. Keep in mind that if you are utilizing insurance funds, third parties may review your medical record to obtain information about diagnosis, treatment process and prognosis for the purpose of treatment authorization, quality care management and payment for services. As a courtesy service, depending on your particular insurance provider, your insurance may be billed. Payment is required at the time of service. You will be required to pay all fees not covered or denied by your insurance.

I understand my insurance will not be billed by my therapist and payment is due when services are rendered. _____ (initial)

I understand that payment is due when services are rendered and that a HICFA 1500 form will be given to me to file with my insurance company for reimbursement. _____ (initial)

I understand that my insurance will be billed. However, total payment is required at the time of service. The name of my insurance company is _____ _____ (initial)

Appointments: Sessions consist of 50 minutes made in advance starting and ending on time. If my child arrives late, the session will still cost full price and ends at the pre-arranged time. Cancelations must be provided at least 48 hours prior to the scheduled appointment. Parent(s) agree to pay the full amount of the session if notice is not given within 48-hour timeframe. We will call Jennifer Hill at (760) 458-1600 at least 48 hours in advance and leave a message in order to avoid being charged. Lateness or cancellations made by the therapist will be rescheduled.

_____ **(initial)**

Please initial the following correspondence options to authorize Jennifer Hill for future communication regarding appointments, billing issues, or other pertinent information regarding my child's treatment.

☐ Voice messages at: _____

☐ Text messages at: _____

☐ Email messages at: _____

Email, texting, and other forms of internet-based communication are non-secure and non-confidential. If we send emails and texts to Jennifer Hill with a response requested, we are willing to accept the risks.

Emergencies:

In the event of an emergency call 911 or (888)724-7240. Jennifer Hill will answer telephone calls during business hours
(9:00am – 6:00pm) on weekdays and Saturdays until 5:00pm.

Only parent(s) or legal guardians can give authorization for the treatment of minors. If both parents have legal custody, both parents' signatures are required for treatment. If there are legal stipulations (a court order) that both parents must consent to ingoing treatment, we agree to contact the other parent/legal guardian and receive his/her consent prior to our child's treatment.

By signing below, I agree to the policies entailed on pages #1, #2, #3. I also agree to receive mental health services from Jennifer Hill MS, LPCC and accept full responsibility for payment for such services.

_____ _____

Parent/Legal Guardian #1 Signature Date

_____ _____

Parent/Legal Guardian #2 Signature Date

_____ _____

Counselor Signature Date