Jennifer Palau, MSW, LICSW

INFORMED CONSENT FOR COUNSELING SERVICES FOR PARENTS AND MINORS UNDER AGE 13: Treatment, Disclosures, Payment Information, & Privacy Rights

THERAPIST CREDENTIALS

I am a Licensed Independent Clinical Social Worker (LICSW) in Washington state, LW00008221. I am also a Licensed Clinical Social Worker in California (LCSW #20401). I have a Bachelor's degree in Psychology from the State University of New York at Fredonia (1992), and a Masters in Social Work from Arizona State University (1994). I am a member of the National Association of Social Workers (NASW). I am intensively trained in Dialectical Behavior Therapy by Behavioral Tech, LLC in Seattle, WA, and am a DBT-Linehan Board of Certification, Certified Clinician™.

RISKS OF THERAPY

There are few known risks associated with counseling. However, some people report a heightened emotional awareness which can bring on stronger emotions. In some cases, people feel more depressed and have thoughts of suicide. Also, as people grow and learn things about yourself, their relationships with others may change. Counseling is a process of change and will not happen overnight.

CLIENT RIGHTS

Until your child is 13 years old, you maintain rights to their records and have control over whether they participate in treatment or not. In divorce agreements, if parents have joint custody then I must have both parents' agreement to treat the child in therapy. If there is a modification to a typical joint custody agreement, I will need a copy of the Parenting Plan to see the custody agreement. In joint custody, either parent can cancel treatment at any time. Regardless of age, the child will be treated with respect and dignity in the therapeutic environment. Parents have the right to obtain a copy of client records or request to amend a record. Parents have the right to file a formal complaint against the therapist. If either parent or the child desires to terminate the counseling contract, it is helpful when this is discussed in advance, so that proper closure, including referrals when appropriate, can be provided.

CONFIDENTIALITY

I maintain the confidentiality guidelines of the Washington Administrative Code (WAC), the Health Insurance Portability and Accountability Act (HIPPA), and the National Association of Social Workers (NASW). I will not disclose any personal or identifying information to anyone outside the therapist-client relationship without a parent's written authorization for clients under the age of 13. Exceptions to confidentiality include: 1) evidence suggests physical, sexual, or emotional abuse and neglect of a child, a disabled individual, or the elderly; 2) the client presents with suicidal ideation and

refuses to comply with safety commitments; 3) the client reports to plan to harm a specific-named individual; 4) where permitted by or required by law (ie, insurance agreement, legal subpoena with proper notice); 5) consultations with my DBT consult group (client identity is omitted in consultation). My duty to provide confidentiality will survive the death of a client unless otherwise authorized by the client prior to death. In the event that I see a client around town, I will not initiate conversation or interaction in order to protect their confidentiality. When the child turns 13, at the next session the child will sign a new Informed Consent form and will need to sign a Release of Information for any adult, including parents, to have information regarding treatment.

EMERGENCIES

If you or the client are unable to reach me in an emergency, contact the **King County Crisis Line, 206-461-3222**, or toll free 1-866-427-4747. If they have a life-threatening emergency, call 911 immediately or go to the nearest hospital emergency room. Please be aware that my email address is not a crisis resource and is not checked regularly.

SOCIAL MEDIA/ELECTRONIC COMMUNICATION

I do not use social media with my clients. I will not accept "friend" requests nor will I communicate with my clients or their family members using social media.
If a client chooses to contact me via cellular phone, text message, email, or fax, she/he understands complete privacy and confidentiality will be at risk due to intercepted calls, technological hackers, or accidentally dialed phone/fax numbers. Clients are responsible for advising me if there is not a safe phone number or address to be contacted, otherwise, I have the right to attempt to contact clients according to the information provided by the client on the Client Info form.

CANCELLATION POLICY

I have a **24-hour cancellation policy**. If your child is sick or otherwise unable to make it to the scheduled appointment, you must contact me at least 24 hours before the appointment. Failure to do so will result in being charged the full session rate. The fee will be due at the beginning of the next session. Insurance companies do not reimburse for missed sessions and you will be responsible for the full fee amount.

FEES AND BILLING PRACTICES

My fee for the initial assessment is $250. My hourly fee for a standard session (50-55 minutes) is $175. At times, I may schedule a longer session (75-80 minutes) at $250. Fees are to be paid at the time of service unless otherwise discussed. I accept cash, check, and credit cards. If you are unable to pay for service, I have the right to terminate therapy and refer the client to a low cost counseling center. There is a $30 fee for returned checks. I am open to phone calls between sessions under 15 minutes. Phone calls over 15 minutes will be pro-rated at my hourly rate. Work such as writing assessments or letters on my client's behalf or talking to other care providers will be pro-rated at my hourly rate. These may not be covered by your insurance and you will be expected to cover these costs.

It is my policy not to become involved in your legal matters (e.g. divorce, custody, immigration, etc). If subpoenaed to testify in court regarding my work with the client, my base fee will be $375/hour and additional fees may apply. During the course of treatment, my fees may change. You will be informed of fee increases in writing. Any outstanding fees (past 60 days) will incur a 5% fee on the balance owed. Collection costs and/or attorney fees will be added to the outstanding balance in the event a collection process is necessary.

I am an **out-of-network provider**, which means fees for service are to be paid at each session. I can provide you with a monthly superbill that you can submit to your insurance for reimbursement which contains the required diagnosis and billing codes. By signing this form, you authorize Jennifer Palau, LICSW to release any necessary protected health information (PHI) for your child on the superbill, if you chose to receive one. It is your responsibility to determine what is and is not covered by your particular insurance.

RECORD KEEPING POLICIES

I will maintain documentation of all consents, authorizations, notices or privacy practices, trainings, and patient requests for records or amendments to records. I will document complaints received and their disposition. Client records will be kept locked in my office or in a locked file cabinet offsite. I will keep client records for seven years from the date of the last treatment session. With respect to the records or a minor, I will keep those records for at least seven years or until the patient is twenty-one years old, whichever is longer. Thereafter, I may destroy client records. When records are destroyed they will be done so in a manner that protects client privacy and confidentiality.

CLIENT AGREEMENT

By signing this form below, I acknowledge I have read and understand the above therapist disclosure, client responsibilities, and treatment contract. I have received or read copies of the HIPPA privacy practice guidelines from Jennifer Palau, LICSW's website. I understand the above responsibilities for my child, and I will participate in the counseling environment as appropriate. I understand that if I withhold important critical information from the therapist, I will be interfering with the counseling progress of my child and I will potentially jeopardize the therapeutic process. I have been given the opportunity to ask questions. I understand this is a legal document and contract. I have been given a copy of this contract.

Parent name_____Signature_____Date_____

DOB for Child in Treatment:_____

Therapist_____Signature_____Date_____