AUTHORIZATION FOR TREATMENT
INFORMED CONSENT & POLICIES (CHILD)

Client Name: _____
Last First Middle

I, _____, parent/guardian of _____, applicant for the services of Child Parent Counseling, LLC (CPC):

1. I authorize a licensed therapist (LCPC, LCSW) employed by CPC, to provide counseling services for my child.
2. I understand that no guarantee or assurance is being made as to the results that may be achieved.
3. My child and I have the right to be treated with respect and courtesy. I will be informed about the reason for treatment, risks, benefits, process of counseling, alternatives and approximate length of treatment.
4. Prior to beginning counseling, CPC will conduct an evaluation and determine a mental health diagnosis or diagnoses, if indicated. CPC and I/my child will then develop a treatment plan that may include individual, family or group psychotherapy, play therapy and/or psycho-educational groups. Options for treatment will be discussed and referrals for me, my child and/or my family to receive other services (psychiatric, educational, recreational, medical, etc.) may be made.
5. My co-payment or full amount, if self-pay, is due at the time of service. CPC accepts payment by cash, credit card or check. A $25 fee for returned checks will be incurred. When applicable, CPC will provide me with a bill that can be used to obtain reimbursement from insurance companies or other sources.
6. If insurance is billed by CPC, I authorize the release of medical information necessary to process any of my child's insurance claims and I authorize payment of medical benefits directly to Child Parent Counseling, LLC for services rendered. I understand that I am responsible for immediately notifying CPC of any insurance changes. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. Should the account be referred to an attorney for collection, I shall pay reasonable attorney fees and collection expenses.
7. I understand that CPC will keep all my personal information confidential, except for the following special situations as required by law or quality assurance:
   a. If I sign a release of information to another agency or person.
   b. If I/my child indicate a desire to hurt myself or someone else, the staff has a duty to ensure people's safety; confidentiality may have to be waived to do so.
   c. If a minor client (17 years old or younger), an elderly client or disabled client indicates that they have been physically or sexually abused, neglected, or abandoned, the staff is required by law to report this.
   d. If a judge issues a court order for the release of records or information.
   e. Insurance providers and CPC periodically review client's charts, to ensure quality client care, provide staff supervision and perform billing functions.
   f. CPC may consult regarding cases with licensed mental health professionals, who are bound to keep the details of such cases confidential, for the purpose of providing the highest quality of care. During these consultations only clinically relevant details will be discussed and no identifying information such as names, places of work, etc. will be used.
8. I agree that in order for CPC to best serve clients, I accept the following policy: appointments may be cancelled if CPC is notified at least one business day before the scheduled session. A $40 no-show fee for appointments cancelled less than 24 hours will be charged payable prior to the next appointment. Repeated no-show appointments may be a reason for termination and referral to other services. CPC may need to cancel appointments from time to time due to unforeseen circumstances. CPC will attempt to give as much notice as possible.
9. I understand that I am protected through a grievance procedure, which is free from coercion, discrimination, and reprisal and that I have the right to file a grievance if it becomes necessary. I will first discuss my concern with my therapist and if still unsatisfied, I will submit a written document to outline my concern to CPC. I understand that if I feel my therapist/CPC is committing an ethical violation, I can contact the Board of Professional Counselors and Therapists or the Maryland Board of Social Work Examiners:
   4201 Patterson Avenue Baltimore, MD 21215-2299 Phone: 410-764-4732 Fax: (410) 358-1610

Client Name: _____
Last First

10. I understand that CPC receives, originates, maintains, discloses, & uses individually identifiable health information, including, but not limited to, health records and other health information describing my child's health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. This information may be used to perform the following tasks: diagnose my child's medical/psychiatric/psychological condition, plan my treatment, communicate with other health professionals concerning my care, and document services for payment/reimbursement, and conduct routine health care operations, such as quality assurance audits. Electronic health records are used to secure your child's information. Any paper records are kept under lock and key.
11. I have the right to refuse treatment for my child. The potential consequences of refusing treatment will be reviewed.
12. I understand that if I or my child's therapist believes that a referral would be appropriate during the course of the counseling relationship, my child's therapist will assist in identifying referral services and in making the referral. Referrals may be made for a number of reasons including: my therapist or I identifying any source of conflict in the relationship, a client need that requires a greater degree of expertise or a different area of counseling specialization, or a need for medical or psychiatric attention. Referrals will be discussed openly and the transfer completed to the best of the therapist's ability.
13. My therapist and I agree to maintain a professional relationship. CPC requests that I do not invite my therapist to social events or solicit for business. If staff from CPC encounters my child, my family or I outside of the counseling setting, CPC staff will not acknowledge the existence of any relationship.
14. I will not leave the premises when my child is in session.
15. CPC primarily communicates through email, text and phone. Please be aware that CPC cannot ensure confidentiality using electronic communication. It is recommended that email and texting does not include clinical information. Electronic records are considered a part of the client's mental health record. Emails, texts and phone calls will be checked daily Monday-Friday by 6pm. CPC will return messages within 48 hours.
16. If there is an emergency situation, please call 911. If there is an urgent situation and CPC is unable to be reached, contact the Anne Arundel Crisis Warmline at 410-768-5522 (24 hours a day, 7 days a week) or the Maryland Youth Crisis Hotline at 1-800-422-0009 (24 hours a day, 7 days a week).
17. I have the right to review my child's records, unless prohibited by law, or deemed harmful to the person.

My signature below affirms that I have had this entire form explained to me, accept the terms and have received a copy of this form. I also consent to the policies in the Notice of Privacy Practices and acknowledge being offered a copy of the Notice of Privacy Practices and a Professional Disclosure Statement. My questions have been sufficiently answered and I certify that to the best of my knowledge, all information supplied by me is correct. I, the parent/guardian, have full legal rights to make health decisions for the identified client. I voluntarily consent to counseling services from CPC.

_____	_____	_____
Parent/Guardian (print name)	Parent/Guardian signature	Date
_____	_____	_____
Parent/Guardian (print name)	Parent/Guardian signature	Date
_____	_____	_____
Client (print name)	Client signature	Date
_____	_____	_____
Therapist (print name)	Therapist signature	Date

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