E L E N A V L A D U, M. S.
Licensed Marriage and Family Therapist
MINOR CHILD
CONSENT TO TREATMENT AGREEMENT

This document describes the structure of therapy and provides for your informed consent if you choose to engage in treatment. This is a way to inform you about my therapy services. Please read and discuss with me any questions you may have about treatment.

CONFIDENTIALITY:

All information disclosed within sessions, the written records pertaining to those sessions are confidential. I will not reveal your information to anyone without your written permission except where disclosure is required by law.

Consultation with the parent or guardian and participation in sessions is an ongoing part of the treatment of a minor child. A parent and/or legal guardian can request information regarding their child's treatment. Such information will be provided with the knowledge of the child and generally at a summary level. It is often necessary for children to develop a "zone of privacy" from their parents in order to feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you are acknowledging that you are aware of and agree to this need for privacy as an important part of your child's treatment.

Limits to confidentiality: You should be aware that the law mandates that a report be made where there is a reasonable suspicion of child, dependent or elder abuse or neglect. Also, I am required to breach confidentiality where a client presents a danger to self or to others. In addition, a court of law may subpoena clinical records.

Using health insurance: Insurance coverage is intended for healthcare related to accidents and illnesses. Therefore, most providers require disclosure of a *mental illness diagnosis* for reimbursement. If you are concerned about the confidentiality of this information, you should contact your insurance carrier. Please be aware that I have no control over the confidentiality of your information once it is submitted to your insurance carrier.

PAYMENTS AND INSURANCE REIMBURSEMENT:

My current standard fee for individual therapy sessions is $100 per 50-minute session and $150.00 per 90-minute couples/family session, payable at the beginning of each session. Payment can be made by check, credit card, or cash (correct change is appreciated). *It is appreciated if you make your check out in advance to save time in the session, payable to Elena Vladu, LMFT.* Fees may increase over time. Any ad-hoc services (e.g., phone calls) over ten minutes will be billed on a pro-rated basis.

I require a valid credit card number on your file to be used in case of no-show or late-cancellation appointments.

Please inform me if any problem arises during the course of therapy affecting your ability to make timely payments. Any services provided such as report writing, phone consultations, or phone sessions that last longer than ten minutes will be billed on a prorated basis.

Insurance Coverage: I am currently a network provider for Anthem Blue Cross. For clients using other health insurance carriers, if you choose to seek reimbursement, I will provide the information required for processing your claim to you or to your insurer. Insurance coverage is intended for healthcare related to accidents and illnesses. Please see my financial policy disclosure for additional details about insurance payments.

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CANCELLATIONS:

Since the scheduling of an appointment reserves that time specifically for you, *a minimum of 24 hours notice is required* for the rescheduling or cancellation of an appointment. The full fee will be charged to your credit card for sessions missed without such notification. Insurance will not pay for missed appointments.

Insurance Coverage: You should be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk and that not all issues, conditions, or problems that are dealt with in psychotherapy are reimbursed by insurance companies. It is your, the client's, responsibility to verify the specifics of your coverage, and to pay for session fees that are not covered.

TELEPHONE & EMERGENCY PROCEDURES:

Please feel free to leave a message at any time on my voicemail. Your call will be returned as soon as possible. During crisis periods, special arrangements can be made as needed for immediate contact should the need arise. I will arrange for coverage by a qualified therapist if I am out of town. In the event of a sudden emergency that requires immediate assistance, call **911 (Police/Ambulance) or 1-800-838-1381(SLO County Hotline).** In addition, leave a message on my voicemail clearly indicating that it is an emergency and where I can contact you and I will contact you as soon as I check my messages.

END OF TREATMENT:

In initial meetings, we will assess whether my services can be of benefit to your child. I do not accept clients I do not believe I can help. In such a situation, I will provide you referrals to other therapists you can contact. If at any point during psychotherapy I assess that the treatment is not effective in helping your child reach their therapeutic goals, I am obligated to discuss it with you and, if appropriate, terminate treatment.

You have the right to terminate your child's therapy at any time. If you choose to do so, I will offer to provide you with names of other qualified professionals whose services you might prefer.

I have read the above treatment agreement. I am the custodial parent or legal guardian of the child entering treatment. I understand and have discussed any questions or concerns with Elena Vladu. I consent to have my minor child participate in treatment. If I am requesting use of my insurance, I also authorize the release of information required/ requested by the insurance company as needed to process my claims.

Child's Name _____ **Age:** _____

Parent(s) or Legal Guardian:

Signature _____ **Date** _____

Signature _____ **Date** _____

Phone: 805-464-6102