Alliance Counseling Group

1 W. Camino Real, STE. 201
Boca Raton, FL, 33432
www.alliancecounseling.net

Informed Consent to Treat & Psychotherapist-Client Contract

Please review, sign, and bring these documents to our first appointment, or email prior to, if you prefer.

Outpatient Services Contract

Welcome to Alliance Counseling; this document contains important information about my professional services and business policies. Please take time to read it carefully and make a note any questions you may have so that we can discuss them at our next meeting. When you sign this document, it represents an agreement between us.

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personality of the therapist and the client, as well as the problems and challenges you bring forward. There are many different methods I may use to deal with the problems you want to address. Psychotherapy is not like a medical doctor visit. Instead, it requires a very active effort on your part. In order for the therapy to be most successful, you will need to work on the areas we talk about both during our sessions and especially in between sessions.

Psychotherapy can have both benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. Therapy often leads to better relationships, solutions to specific problems and significant reductions in feelings of distress, however, there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will entail and develop a treatment plan to follow should you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a significant commitment of time, money and energy, so you should be very careful about the therapist you select. If you have any questions about my approach or procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to set up a meeting with another mental health professional for a second opinion.

Meetings

I normally conduct an evaluation that will last for 1 to 2 sessions. During this time, we can both decide whether I am the best person to provide services to you in order to meet your treatment goals. If psychotherapy begins, I usually schedule one 45-minute session per week at a time we mutually agree on, although some sessions may be longer and in some cases require a higher degree of frequency (e.g., two or more sessions per week). Once an appointment is scheduled, you will be expected to pay for the session unless 48 hours advance notice is given, or unless we both agree that you are unable to attend due to circumstances beyond your control. If at all possible, I will try to find another time to reschedule the appointment.

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Billing and Payments

You will be expected to pay for your session at the end of each appointment, unless we agree to other arrangements. Payment schedules for other professional services will be agreed to when they are requested. In certain circumstances of unusual financial hardship, I may be willing negotiate a fee adjustment or payment installment plan. Please be aware that my services do not extend to include any involvement in legal procedures.

In the highly unlikely event that your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I reserve the right to use legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, collection costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his or her name, the nature of the service provided and the amount due.

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate the resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of fees. Thus, it is very important that you find out exactly what mental health services your policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. I will provide you whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed health care plans, such as HMOs and PPOs, often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with the information once it is in their hands. In some cases, they may share information with a national medical information databank. Upon request, I will provide you with a copy of any report I submit if you request it in writing. It is important to remember that you also have the right to pay for therapy yourself to avoid the problems described above unless prohibited by contract.

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Contacting Me

I am often not immediately available by telephone. While am usually in my office during business hours, I do not answer my phone when I am with a client. When I am unavailable, my phone is answered by voicemail which I monitor frequently. I will make every effort to return your call on the day you make it with the exception of holidays and weekends. If you are difficult to reach, please let me know of times when it's best to reach you. If you are unable to reach me and feel you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the clinician, psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact if necessary.

Professional Records

You are entitled to receive a summary of your records. Because these are professional records, they can be misinterpreted by and/or upsetting to untrained readers. For this reason, psychotherapy notes are not released for review; however, at your request I will provide a treatment summary unless I believe that to do so would be emotionally damaging. If that is the case, I will be happy to send the summary to another mental health professional who is working with you. You should be aware that this will be treated in the same manner as any other professional service and will be billed accordingly. Clients will be charged an appropriate fee for any professional times spent in responding to information requests.

Minors

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to require an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you have about what I am prepared to discuss.

Confidentiality

In general, the law protects the privacy of all communications between a client and psychotherapist, and I can release information about our work to others only with your written permission. However, there are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order me to testify if he or she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child or vulnerable adult is being abused, I am a mandated reporter and am legally obligated to file a report with the appropriate state agency (DCF). If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may require notifying the potential victims, contacting the police (or other law enforcement agency), or seeking hospitalization for the client. If the client threatens

to harm himself or herself, I may be obligated to seek hospitalization for him or her, and/or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If such a situation occurs, I will make every effort to discuss it with you before taking any action. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these professional consultations unless I feel that it is important to our work together.

While this written summary of exemptions to confidentiality should prove helpful to information you about potential problems, it is important that we discuss any questions or concerns you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signature of client (or parent of minor) _____

Name (printed) _____ Date _____

I hereby consent to be treated and have been informed of the limitations and risks:

_____ _____

Signature Date

Please note that a minimum of 24 hours notice is required for cancellations

or rescheduling to avoid the full fee (unless otherwise specified) being due.

_____ *(Initial)*

Please review, print, sign, and bring these documents to our first appointment, or email a scaned completed copy prior to our first appointment, if you prefer. Please indicate the clinician with whom you will be working; email addresses are provided so that you may send these forms to her/him if you choose:

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- Dr. Andrew Baker - andrewbakerlmhc@protonmail.com
- Dr. Patricia Diaz - pdiaz@alliancecounseling.net
- Dr. Robert Freund - rfreund@alliancecounseling.net
- Dr. Paul Peluso - drpaulrpeluso@gmail.com

Child and Family History

Form completed by: ( ) Parent ( ) Foster Parent ( ) Guardian ( ) Other _____

Are you a single parent? ( ) Yes ( ) No

Child's name: _____ DOB: _____ Age: _____

Gender: ( ) Male ( ) Female

Grade: _____ Name of School: _____ How long at this school? _____

Referred by: ( ) Parent/Guardian ( ) Pediatrician ( ) School ( ) Social Services ( )

Court order ( ) Other: _____

Address: _____ City: _____ Zip code: _____

Telephone: Home: _____ Work: _____

Cell:_____

Parent's Email Address: _____

It's okay to leave a message at: ( ) Home ( ) Work ( ) Cell ( ) Email

Preferred Method of Contact: _____

Race/Ethnicity: _____

Emergency contact person: _____

Relationship: _____ Telephone: _____

Consent for Child Treatment

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I am the parent/legal guardian of _____ with full legal authority to consent to evaluation and treatment. I hereby give permission for (select one)

- ☐ Dr. Andrew Baker - andrewbakerlmhc@protonmail.com
- ☐ Dr. Patricia Diaz - pdiaz@alliancecounseling.net
- ☐ Dr. Robert Freund - rfreund@alliancecounseling.net
- ☐ Dr. Paul Peluso - drpaulrpeluso@gmail.com

to provide treatment for this child which may include assessment, advocacy, referral and mental health counseling.

Signature: _____ *Date:* _____

Print name: _____ *Relationship to child:* _____

Signature (2nd parent/guardian): _____ *Date:* _____

Print name: _____ *Relationship to child:* _____

Type(s) of service desired:

( ) Child therapy

( ) Adolescent therapy

( ) Family therapy

( ) Referral for psychiatric evaluation

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Child's main challenge/major reason for seeking help at this time:

_____

_____

_____

_____

How long has your child been experiencing these problems, symptoms or issues?

_____

_____

Has your child had treatment for these issues in the past? ( ) Yes ( ) No

If yes, was the treatment helpful? ( ) Yes ( ) No

Has your child received inpatient mental health treatment? ( ) Yes ( ) No

Briefly describe treatment including dates, name of facility/therapist, presenting issues and outcome: _____

_____

_____

Please describe any other behavior or emotional problems your child is having:

_____

_____

What is the impact of your child's problems on the family:

_____

_____

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What are your child's strengths and unique abilities:

_____

_____

Has your child taken illegal drugs or abused prescription drugs? ( ) Yes ( ) No If yes,

please elaborate: _____

_____

Has your child been caught drinking alcohol? ( ) Yes ( ) No

If yes, please elaborate: _____

_____

Is your child currently under the care of a physician or psychiatrist? ( ) Yes ( ) No

Treatment for: _____

If yes, Doctor's name: _____ Telephone number: _____

Is your child currently taking any medications? ( ) Yes ( ) No

If yes, please include the following information:

Name of medication(s)	Dosage	Prescribed by
_____	_____	_____
_____	_____	_____

Does your child have a history of abuse (physical, sexual, emotional or neglect)?

( ) Yes ( ) No

If yes, please describe briefly, including dates, location, perpetrators, type of abuse and

impact on child and family: _____

_____

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Is there legal action pending related to accusations of abuse? ( ) Yes ( ) No

If yes, please describe: _____

_____

Is there any other legal action that may have impacted your child?

Please check all that apply:

	Current	Past		Current	Past
Custody	( )	( )	Visitation	( )	( )
Adoption	( )	( )	Child Protection Services (DCF)	( )	( )
Probation	( )	( )	Other _____	( )	( )

If yes, please describe: _____

_____

_____

Forms of discipline used in the home:

( ) Time out ( ) Loss of privileges ( ) Grounding

( ) Rewards/incentives ( ) Extra chores ( ) Physical punishment

( ) Other: _____

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BEHAVIOR CHECKLIST

BEHAVIOR	Current	Past	BEHAVIOR	Current	Past
Crying, sadness, depression			Temper tantrums		
Loss of enjoyment of usual activities			Irritable, angry		
Expressing a wish to die			Argumentative		
Bedtime fears, won't sleep			Disobedient		
Threatened or attempted suicide			Does things that annoy others		
Worries more than others			Unusual fears or phobias		
Panics			Anxious or nervous		
Repeats unnecessary act over and over			Overly concerned about things		
Has rituals, habits, superstitions			Twitches or unusual movements		
Eats very little/fasts to lose weight			Binge eating		
Sleepwalking			Blames others for own mistakes		
Withdrawn			Easily annoyed by others		
Nightmares or night terrors			Swears or uses curse words		
Low self-esteem			Wants to run away		
Wakes early, unable to go back to sleep			Sneaks out at night		
Tiredness, fatigue			Injures self		
Restless sleep, wakes frequently			Stealing		
Difficulty falling asleep			Lying		
Sleeps too much			Hurts animals		
Poor appetite			Destroys property		
Under- or over-weight			Hurts people		
Over-activity			Drug use		
Frequently acts without thinking			Alcohol use		

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Doesn't finish things			Cigarette use		
Disruptive			Sexual problems		
Short attention span			Problems with authority		
Daydreams, fantasizes			Problems with the law		
Easily distracted			Low motivation		
Hallucinations (sees/hears things that others don't)			Vomits intentionally		
Bedwetting / daytime accidents			Soiling in pants		
Strange or unusual behavior			Disorientation		
Other _____			Other _____		

Relationship Development (Check each item that describes your child)

	Current	**Past**		**Current**	**Past**
Prefers to be alone			Is demanding and bossy		
Is alone a lot, but dislikes this and feels lonely			Fights with others		
Is shy			Bullies others		
Has few friends			Teases a lot		
Has many friends			Plays with younger kids		
Plays with "problem" kids			Plays with older kids		
Is picked on a lot			Poor relationships with peers		
Is overly sensitive			Conflict with parents/step-parents		
Poor relationships with teachers			Has difficulty getting along with brothers and sisters		

School (Check each item that describes your child)

	Current	**Past**		**Current**	**Past**
Dislikes school			Missed many school days		
Works hard but doesn't do well			Repeated a grade		

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Unmotivated, refuses to complete work			Discipline referrals, detentions		
Learning problems			Suspensions		
Expulsions			Other _____		

If your child has been suspended or expelled, please explain: _____

_____

_____

_____

Academic Development (Check each item that describes your child)

	Current	Past		Current	Past
Resource classes / special ed.			Continuation school		
Gifted program			Home study		
Speech therapy			Independent study		
Other programs					

If other programs apply, please explain: _____

_____

Family Stressors (Check each item that describes your child)

	Current	Past		Current	Past
Marital problems			Housing problems		
Marital separation			Legal issues		
Divorce			Death of a friend		
Custody disputes			Death of a relative		
Financial problems			Death of a pet		
Job loss			Family illness		
Parents using alcohol/drugs			Other stressors: _____		

If other stressors are present, please explain: _____

_____

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Developmental History During pregnancy, did the child's mother experience any of the following:

( ) alcohol ( ) drugs
( ) illness ( ) accident
( ) problems with pregnancy ( ) problems with labor
( ) problems with delivery ( ) premature delivery

If yes to any of the above, please explain: _____

_____

Please check if child is/was delayed in any of the following areas:

( ) holding head up ( ) turning over ( ) sitting up
( ) crawling ( ) walking alone ( ) weaning
( ) feeding him/herself ( ) potty training ( ) using single words
( ) using sentences ( ) dressing him/herself
( ) sleeping through the night

Please briefly explain any delays: _____

_____

_____

_____

_____

As a baby/toddler, was the child (check all that apply):

( ) eating well ( ) colicky
( ) head banging ( ) performing rocking behavior
( ) clumsy ( ) wanting to be left alone
( ) easy to regulate (sleeping/eating) ( ) adaptable to transitions
( ) more interested in things than people ( ) easy to soothe
( ) performing daredevil behavior

Medical History (Indicate if your child has had any of the following):

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Condition	Yes	No	Age	Details
Serious infection				
Convulsions/seizures				
Head injuries				
Other injuries				
Hospitalizations				
Surgeries				
Ear infections				
Poisonings				
Allergies				
Asthma				
Alcoholism				
Drug Use				

Does your child have any other medical conditions? ( ) Yes ( ) No

If yes, please describe: _____

_____

Does your child frequently complain of body aches and pains? ( ) Yes ( ) No

If yes, please describe: _____

_____

Does your child miss school because of his/her physical complaints? ( ) Yes ( ) No

If yes, please describe: _____

_____

Does your child have any allergies to medications, drugs or foods? ( ) Yes ( ) No

If yes, please describe: _____

_____

Family information: Please list all of the people who currently live with the child:

Name	Age	Relationship	Occupation/School & Grade

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Indicate if any family members or relatives have the following:

	Mother	**Father**	**Brother**	**Sister**	**Other (please specify) (aunts, uncles, cousins, grandparents, etc.)**
Problems with attention, activity or impulse control as a child					
Learning disabilities					
Did not graduate from High School					
Alcohol abuse					
Drug use					
Problems with aggression					
Antisocial behavior (arrests, jail, legal problems, probation, hurting animals, etc.)					
Abuse victim					
Abusive to others					
Depression					
Nervous disorders (anxiety)					
Mental retardation					
Serious illness or surgeries					
Physical handicaps					

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Tics or unusual movements					
Other mental health problems					

What are your family supports? (church, friends, relatives, clubs, etc.)

_____

_____

What are your family's strengths?

_____

_____

Please list any adults who are authorized to drop off or pick up your child from his or her therapy session in the event you or another legal guardian are unavailable:

_____

Please note:
An authorized adult must remain in the waiting room at all times when a minor is in a therapy session.

I authorize the above named person(s) to bring my child from his/her therapy session. I agree that I or any person named by me (listed above) will not leave the premises and will remain in the waiting room for the duration of my child's therapy session.

_____ _____
Child's name *DOB*

_____ _____
Print Parent/Guardian Name *Relationship to child*

_____ _____
Signature *Date*

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AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

Client Name: _____ Date of Birth: _____
This will authorize the clinician specified _____ to disclose and/or obtain from:

_____

The following information: (Client must check and initial each item to be included)
[ ] Assessments _____
[ ] Psychosocial evaluation _____
[ ] Treatment plan or summary _____
[ ] Progress in treatment _____
[ ] Discharge / Transfer summary _____
[ ] Other (please specify) _____

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If there is another purpose, please specify:

_____.

Right to Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Dr. Rob Freund, LMHC, NCC at the address listed above. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration:
[ ] This information release is for a specific instance, valid for 90 days, and will expire on the following date: _____.
[ ] Unless sooner revoked, this consent is valid for 1 year due to the need for ongoing communication for the coordination of treatment and will expire on the following date: _____.

Conditions: I understand that the clinician will not condition my treatment on whether or not I give authorization for the requested disclosure.
Form of Disclosure: Unless you have requested in writing that disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner deemed to be appropriate and consistent with applicable law, including but not limited to verbally, on paper or electronically.
Re-disclosure: Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

_____ _____
Parent/Guardian (if applicable) Date

_____ _____
Parent/Guardian/Witness Date