Juniper Campbell, LPC

Consent for Treatment on Behalf of a Minor

I understand that my minor child will be engaging in psychotherapy with Juniper Campbell. The purpose of this treatment is so my child feels better or resolves specific life or adjustment problems that have caused me to seek assistance on behalf of my child. The primary procedure used by Ms. Campbell is "talk" therapy, although I understand that she may also provide general education to my child or to me about behavioral health conditions or coping strategies. She has specialized training in Cognitive Behavioral Therapy, Person Centered Therapy, EMDR, and Equine Therapy. Use of some of these techniques may require that I sign additional Consent for Treatment documents. I have had the opportunity to ask any questions I may have about any of the techniques used by Ms. Campbell.

The potential benefit of treatment is that my child will feel better about his or her life. My child may experience a reduction in feelings of distress, increased satisfaction in relationships, greater personal awareness and insight, or increased skills for managing stress. I understand that a "cure" is not guaranteed and it is possible that as my child talks about some things, he or she may even feel worse. The therapeutic process may bring on strong feelings such as sadness, anger, guilt, frustration, or anxiety. He or she may experience emotions more intensely as he or she talks about things that are upsetting, or I may notice more conflict in relationships as my child makes changes. Ms. Campbell will assist my child in understanding that psychotherapy will require a very active effort on his or her part and that in order for it to be most successful, he or she will have to be open and honest and will need to work on things discussed during therapy outside of sessions.

I understand that all information my child shares will be kept confidential, but that this confidentiality is not absolute. In the case of medical emergency, child/elder abuse or neglect, suicidal or homicidal intent, or under court order, clinical information may be released. I also understand that if I elect to have my child's treatment paid for by an insurance company, Ms. Campbell will release clinical information to my insurer. In such cases, only that information required for billing will be released. I further understand that Ms. Campbell, my child, and I will discuss and agree upon the extent to which information my child provides to Ms. Campbell is shared with me. However, regardless of the results of this discussion, I understand that I can have a copy of my child's records provided to another person or to me by completing a Release of Information form and that a fee may be charged for this service. I have been provided with both a Notice of Privacy Practices required by the Health Insurance Portability and Accountability Act (HIPAA) and a document "Additional Information About My Practice" which address confidentiality in more detail and have had the opportunity to have any questions answered.

I understand that all services provided by Ms. Campbell are LGBTQIA-inclusive and gender-affirming. This means that as a therapist, Ms. Campbell will support my child in exploring gender and sexuality should these topics arise during treatment.

I understand that Ms. Campbell is an independently licensed professional counselor. However, in an effort to provide services that reflect best practices, she has contracted with Laurie Verdier to provide consultation/supervision. Ms. Verdier's phone number can be provided upon request if I have questions. In addition, she occasionally consults with various experts and peers. I understand that Ms. Verdier as well as any experts or peers are bound by the same rules regarding confidentiality as is Ms. Campbell.

I understand that both my child and I have the right to participate in treatment decisions and that Ms. Campbell and my child will together develop and periodically review and revise a treatment plan which will identify goals for treatment as well as the means of achieving those goals. I understand that I have the right to refuse any recommended treatment for my child and that I may withdraw my consent to treatment at any time with any consequences clearly explained to me.

I understand that payment is due at the time of service unless other arrangements have been made. Ms. Campbell's current fee for self-pay sessions is $150 for the intake session and $135/hour for additional clinical sessions. She reserves the right to change fees with 30 days-notice. Payment may be made via cash or check. A $25.00 service charge will be incurred for any checks returned for any reason. **Late cancellations** (<24 hours) **or No-Show will incur a fee of $80** although Ms. Campbell may waive this fee at her discretion. I understand that I am responsible for making arrangement so that my child arrives to their session on time. If they are late, their session will still end at the regularly scheduled time. I understand that insurance companies do not pay for missed appointments. Extended sessions, telephone calls over 15 minutes, report writing and reading, attendance at meetings with other professionals I have authorized, and time spent performing other services I have requested will be charged at the rate of $33.75 per 15-minute increments. If I cannot afford the fee for psychotherapy for my child, I can talk with Ms. Campbell about the possibility of a hardship discount. The cost of therapy services is my responsibility. If I am using insurance, I understand that I am responsible for all payments in the event that my insurance does not cover services. I am also responsible for any deductibles or co-pays required by my insurance company. I understand that unpaid balances past-due over 90 days may be referred to a collection agency.

I understand that it is not the role of my child's therapist to gather information for the courts or to make judgments related to my family. I agree that I will not ask Ms. Campbell to provide treatment records or to testify in any future divorce or custody action. I understand that the courts can appoint professionals who have had no prior contact with my family to conduct independent evaluations and make recommendations to the court. I understand that I am discouraged from having Ms. Campbell subpoenaed. I understand that should she have to appear in court, I will be required to pay substantial fees, including fees associated with travel, time actually spent, and time away from office. There may be additional fees associated with Ms. Campbell becoming involved in a court case.

I understand that unless other arrangements have been made, my child's case will be closed if he or she does not see Ms. Campbell for 30 days. Should this occur, he or she can return for a new Episode of Care, but that in such a case, I will have to sign a new Consent to Treat and the Treatment Plan will have to be reviewed to determine if goals remain the same or if a new Treatment Plan needs to be developed.

I have read the above information and consent for treatment. The HIPAA Notice of Privacy Practices and Additional Information About My Practice handout are incorporated by reference into this document.

I attest that if both parents are not signing,

my child's therapist has been provided with a copy of a custody agreement documenting that I have the sole right to make medical decisions.

my child's other parent cannot be located, is deceased, unknown, or my child was conceived via donor insemination.

Printed Name: _____

Signature: _____ Date: _____

Printed Name: _____

Signature: _____ Date: _____

Therapist: _____ Date: _____