

P. Delia Brinton, MFT

License # MFT 38911
100 Tamal Plaza, #108
Corte Madera, CA 94925
415-924-2638
415-924-1638 FAX

Informed Consent for Treatment of a Minor

I/we, _____, hereby authorize Delia Brinton, MFT to provide psychotherapy to my/our son/daughter , _____ on a 50 minute per session basis for a period of time to be determined by mutual agreement. We/I understand that it is to the benefit of our son/daughter to thoroughly and openly discuss with Ms. Brinton readiness to terminate therapy, when the time comes. I/we understand that the purpose is (1) to improve interpersonal/family relationships; (2) to increase my/our child's ability to function effectively at home and in school, but there is no guarantee that this will occur. Initials_____

My son/daughter is to be seen by Ms. Brinton

in individual therapy

in family therapy

When my/our child is seen in individual therapy, I/we understand that as part of treatment of my/our child, I/we may be expected to meet with Ms. Brinton at regular, agreed upon intervals.

Initials_____

I/we understand that maximum benefit will occur with consistent attendance and that I/we will support my/our child to keep regular appointments. If there is a need to cancel or change an appointment I/we will give as much advance notice as possible. I/we agree to pay for a missed appointment if, **for any reason**, I/we have not given at least 24 hours notice. Initials_____

I/we understand that Ms. Brinton may be out of town for conferences/ meetings or vacation/ family times (6-10 weeks per year). She will give advance notice of these times whenever possible.

She will leave the name and number of a qualified professional to call in her absence on her answering service. Ms. Brinton checks her messages regularly; however, she is not available by phone on a 24 hour basis and does not carry a pager. In case of an emergency I/we understand that I/we may call the Psychiatric Emergency Service at Marin General Hospital at 499-6666. Initials_____

I/we understand that payment of \$_____is due at the beginning of each session unless other arrangements are made. I/we understand that the fee may periodically be increased (usually once a year); one month notice will be given before a fee increase. I/we understand that short phone calls to Ms. Brinton for consultation will be included in this fee. If longer phone calls are regularly necessary either with me/us or with my/our child's school, I/we understand that Ms. Brinton will inform me/us and charge me/us for these additional calls on a pro-rated basis. I/we understand that Ms. Brinton's full fee is \$_____ and she may, at times, be able to offer a sliding scale fee if circumstances warrant that. I/we understand that if I/we wish to bill an insurance carrier, Ms. Brinton will provide a statement and it is my/our responsibility as the client(s) to follow through. Initials_____

For couples and families in therapy. If one member of the family or couple shares something with the therapist which is unknown to the other (s), it is acknowledged that some such withheld information may radically undermine the potential of the therapeutic work. Therefore, Ms. Brinton has a "no secrets policy." Ms. Brinton will assist the clients in being able to communicate to each other and, **if appropriate**, to ultimately find a way to disclosure in the therapy. Initials_____

Confidentiality Notice: The confidentiality of client information and records received or documented during the course of psychotherapeutic treatment is protected by both the legal and ethical standards pertaining to Marriage and Family Therapy. These guidelines provide that all conversations and documents pertaining to a client's history and treatment will remain strictly confidential and privacy will be protected by the Therapist. Therefore, information will not be released to any other individual or organization without the prior written consent of the client. Initials_____

However, there are also legal and ethical regulations that have created certain exceptions which allow for disclosure of information. These include the following situations:

1. **Suspected child abuse or neglect.** If information is obtained during the course of treatment that a minor is or may be the victim of abuse or neglect, this information will be released immediately to appropriate authorities.
2. **Suspected elder abuse or neglect.** If information related to abuse/neglect of a person 65 or over is obtained during the course of treatment, this information will be immediately released to appropriate authorities.
3. **Suspected intention to do serious physical harm to another person** If intent to harm another person is revealed by the client during the course of treatment, information will be shared as necessary to prevent this harm.
4. **Suicidal intent.** The therapist may disclose information to others regarding the client's mental status if suicide or self-harm is determined to be a risk.
5. **Court Order.** Disclosures may be compelled by a judge, coroner, arbitrator or others in the legal system.

I/we also understand that when my/our child is in individual therapy Ms. Brinton will share with me/us some very general information about the progress of my/our child in psychotherapy. However, my/our child will also be given the benefit and privacy of confidentiality as defined by law and ethics. Initials_____

I/We have read and understand these policies.

Parent Signature

Date

Print Name

Address

Phone Number (s) May leave message 📞 May not leave message 📞

Parent Signature

Date

Print Name

Address

Phone Number (s) May leave message 📞 May not leave message📞

I have read and/or have had explained to me the above policies.

Signature of Minor

Date

Birthdate