INSIGHTS COLLABORATIVE THERAPY GROUP

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Dallas, Texas 75231
214.706.0508
www.insightstherapy.com

INFORMED CONSENT TO TREAT
(Minor)

THERAPIST: MARY D. SANGER, M.A., LPC-S, LMFT-S, LCDC

EDUCATION:

Master of Arts in Counseling, Argosy University, Dallas, Texas
Bachelor of Arts in Psychology, Argosy University, Dallas, Texas

LICENSES:

Texas Licensed Professional Counselor (Supervisor) (#63701)
Texas Licensed Marriage and Family Therapist (Supervisor) (#201295)
Texas Licensed Chemical Dependency Counselor (#10981)

TECHNIQUES, GOALS, AND PURPOSES OF THERAPY: Although I use various therapy methods, my primary therapy method is Bowen Family Systems. This means I look for predictable patterns in relationships which are causing your child distress. I work on the belief your child can learn to identify these patterns for himself/herself and learn solutions that can ultimately lead to happiness in work, love, and play. We will discuss and I will determine which therapy method we will use. As we progress, the therapy method may change and I may employ other therapy methods. Additional types of therapy, such as support groups or therapy groups, may also be appropriate in his/her situation.

There may be alternative ways to effectively treat the problems your child is experiencing. It is important for you to discuss any questions you have about the recommended treatment and to have input into setting the goals of your child's therapy. We will discuss the initial goals, purposes, and techniques of therapy in our first two sessions.

Through therapy, it is hoped that your child will be better able to understand his/her situation and feelings and move toward resolving his/her difficulties. Using my education and knowledge of human development and behavior, I will make observations about situations as well as suggestions for new ways to approach them. It is important for your child to explore his/her own feelings and thoughts and to try new approaches in order for change to occur.

COLLABORATIVE PRACTICE: Insights is a collaborative practice which offers a team approach to every client's case, including your child's. This means our Insights team of mental health professionals may discuss and collaborate on cases, including your child's case. You consent to this collaborative process.

RISKS OF THERAPY: There is always a risk of psychological side effects from psychotherapy. Sometimes symptoms worsen before they improve. Often therapy brings up painful emotions. In therapy, your child may learn things about himself/herself that he/she doesn't like. Often growth cannot occur until your child experiences and confronts issues that induce him/her to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts and the realization that your child is responsible for lifestyle choices/changes that may result from therapy. Our goal is to confront issues and emotions together, and with time, to work through them.

LENGTH OF TREATMENT: Length of treatment is difficult to predict. Each child has unique strengths and weaknesses, and each problem is different from the next. Together we will decide how often your child should come to therapy. It is my goal that each

client will finish therapy in a timely manner, without unnecessary expenditure of time or money. Faster progress will likely be achieved if between sessions your child thoughtfully reflects on the topics and techniques we discuss during our sessions. It is helpful if your child comes to his/her sessions with his/her thoughts, feelings and questions.

SESSIONS; CANCELLATIONS: Each 50-minute session costs $190; each 80-minute session costs $290. Sessions are by appointment only and are scheduled at the end of each session, by calling the Insights office or me (Monday through Friday between 9:00 A.M. and 5:00 P.M.), or by using the online client portal. **You agree to pay for missed or canceled sessions unless you call at least 24 hours in advance to cancel or reschedule the session.** (Exceptions may be made in emergency situations.) Most insurance companies do not reimburse for missed or canceled sessions.

FEES AND PAYMENT: Each 50-minute session costs $190; each 80-minute session costs $290. Session fees are due at the end of each session. You agree to pay all session and other fees when due. In many cases, insurance will reimburse you for all or part of the fee. I do not file insurance claims for you; you must do this on your own. However, I will provide you appropriate documentation for you to give your insurance company.

Non-session time related to your child's case costs $380 per hour (prorated in 15-minute increments). You agree to pay for all non-session time, plus reasonable expenses and legal fees, unless payment is agreed upon in advance by a third party in a written document prepared by me. "Non-session time" includes, but is not limited to, offsite visits, consultation with third parties, report writing and reading, travel time, and preparation for depositions, hearings and trials. I may require advance payment for these fees and expenses, which will not be reimbursed by your insurance.

If I am asked or subpoenaed to attend or testify at depositions, hearings or trials (even if you are not the person who asked or subpoenaed me to attend or testify) concerning your child's case, you agree to pay me $3,040 per day (or any part of a day), plus reasonable expenses and legal fees, none of which will be reimbursed by your insurance. I may require payment for these fees and expenses 48 hours before the scheduled court appearance or deposition. You expressly authorize me to obey subpoenas and to disclose requested information.

When I go to court or give a deposition, I have to clear my schedule and not schedule other clients, so there is a minimum 48-hour cancellation policy for court proceedings and depositions. If my court appearance or deposition is cancelled less than 48-hours before the court appearance or deposition is scheduled, you agree to pay all fees for the court appearance or deposition even though they did not take place and are **non-refundable**. Clearing my schedule to attend or testify at depositions, hearings and trials disrupts my daily schedule for other clients.

For fees and expenses which you do not pay by check or in cash, you authorize Insights to charge those fees and expenses (plus an administrative charge) using the credit/debit card information you provide to Insights.

OUR RELATIONSHIP: The relationship between your child and me is professional and therapeutic, rather than personal. It is vital to maintain the professional nature of this relationship, so personal, social and business activities of any kind between us are inappropriate because they undermine the effectiveness of the therapeutic relationship. Gifts, bartering, and trading services are not appropriate. Sexual intimacy between a therapist and a client is always inappropriate and illegal. If this has happened to your child in the past, I am required to report it to the Office of the District Attorney in the county where your child lives and report it to the licensing board of your previous provider. Also, you should file a complaint with the appropriate licensing agency. I am the sole therapist responsible for your child's therapy. You release Insights and its other therapists from all aspects of the therapeutic relationship between you and me.

By signing this Informed Consent to Treat, you represent to me that you are a parent or legal guardian of the child and that you have the legal right to consent to psychological treatment of your child.

If there is any decree of divorce or court order in place which contains provisions regarding parents' or guardians' rights to consent to psychological treatment of your child, you agree to provide me a copy of that decree of divorce or court order before commencement of your child's treatment.

If the decree of divorce or court order provides that you have the sole right to consent to psychological treatment of your child, or if the decree of divorce or court order provides that each parent or guardian has the independent right to consent to psychological treatment of your child, you must sign this Informed Consent to Treat. If the court order provides both parents or guardians have the joint right to consent to psychological treatment of your child, both parents or guardians must sign an Informed Consent to Treat. In all such cases, you understand that I may communicate with the other parent or guardian about your child's case if and to the extent I believe it is in the best therapeutic interest of your child for me to do so.

In my practice, if either or both of your child's parents have remarried or if there are other significant adults who may be involved in the child's therapy, I may deem it appropriate to meet with a step-parent, guardian or another adult. Before doing so, I will require

your signed written consent for me to communicate with the step-parent, guardian or other adult about your child's case if and to the extent I believe it is in the best therapeutic interest of your child for me to do so.

No adults should ask to speak with me in front of the child, before or after your child's appointment. If you have information to share with me, please do so privately. I will require you to sign a written consent before your child's step-parent, guardian or other non-parent caregivers will have the right to schedule therapy appointments for your child.

CONFIDENTIALITY AND LIMITS ON CONFIDENTIALITY: In general, all communications between you and your child's therapist are confidential and protected by law, and I can only release information about our work to others outside our relationship with your written permission. However, the privacy and confidentiality of our communications are not absolute. A few exceptions are outlined below:

1. If you or your child is involved in a court proceeding and a request is made for information concerning your child's diagnosis and treatment, such information is protected by the therapist-client privilege law. I cannot provide any information without your written authorization. However, if your child's records are subpoenaed or if a judge issues a court order for your child's records, I am legally obligated to comply. In the case of a subpoena, I will contact you so you (and/or your attorneys) can take steps to contest the subpoena. If you do nothing to contest the subpoena within three (3) days after being notified by me, I will obey the subpoena.

2. If I believe that your child is a danger to himself/herself or to other persons, I will contact medical or law enforcement personnel.

3. If your child discloses information that leads me to suspect that a minor, elderly, or disabled person is being abused or neglected, I am required by law to notify authorities within 48 hours and I will comply with this requirement.

4. If you or your child files a lawsuit or a complaint against me for any reason related to your child's therapy, I am allowed to use confidential information to defend myself.

5. If a court order or other legal proceeding or statute requires disclosure of your child's information, I will obey the court order or the law.

6. If you waive the rights to privilege or give written authorization to disclose information, I will comply with your authorization.

7. Information contained in communications via computers with limited security/control, such as e-mail and telephone conversations via cell phone is not secure and can compromise your privacy.

8. If I learn of previous sexual exploitation by a mental health provider, I am required to report it to the district attorney in the county of the alleged exploitation and the appropriate licensing board of the provider. You or your child may have the right to remain anonymous when the report is filed.

Most insurance companies require a clinical diagnosis to reimburse for treatment. Some may require additional clinical information to support payment. Information collected by an insurance company will become part of the company's files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their possession. Medical data has been also reported to be legally accessed by enforcement and other agencies, which may place you in a vulnerable position. The safest way to protect confidentiality is to pay cash for treatment.

By your signature below, you acknowledge that you have been advised of these limits to confidentiality and potential risks. If you elect to use insurance coverage to pay for treatment, I will assume that you have evaluated the stated risks and elected to proceed.

Information revealed to me by one parent or guardian is not confidential as to any other parent or guardian, and I may share that information with any other parent or guardian if I determine it is in the best therapeutic interest of the child to do so.

You waive your right to require me (a) to discuss the details of your child's case with you, and (b) to release your child's records (except billing records) to you, unless I deem it is in your child's best therapeutic interest to do so.

CONSULTATION WITH OTHER PROFESSIONALS: At Insights, I often collaborate with other Insights therapists about cases, which may include personally identifying information about your child if we discuss his/her case. It is sometimes appropriate for me to consult with outside professionals about certain cases. Therefore, it is possible that I will discuss your child's case with outside therapists to gain information or insight about your child's situation. If this occurs, your child's name and identity will not be revealed during these discussions. Your insurance company may contact me about the progress of your child's therapy.

TELEHEALTH: We may have telephone sessions or video conference therapy sessions ("telehealth sessions") only if we both agree it would be appropriate to do so. You consent to the following: (1) you assume sole responsibility for securing a telehealth location that is private, quiet and confidential; (2) you understand that a telehealth session may be disrupted due to technical difficulties or intercepted by an unauthorized party; (3) you understand that the privacy and confidentiality (and exceptions to confidentiality) of telehealth sessions are identical to those of the privacy and confidentiality (and exceptions to confidentiality) of face-to-face sessions stated in this Informed Consent to Treat; and (4) you understand that telehealth sessions and related technology may not be HIPAA-compliant. You and your child agree not to audio or video record any telehealth session. We each have the right to terminate a telehealth session or cease telehealth sessions at any time for any reason.

RECORDING DEVICES: You agree not to audio or video record any session without my prior written consent in each instance. For this reason, you agree to turn your smart phone and any other devices with microphones (such as tablets and laptops) off when you are in the Insights offices. These devices generally have voice control turned off; however, you acknowledge that snippets of our conversations may be unintentionally recorded on your device and sent to a third party. If you prefer not to take this risk with your devices, it is your responsibility to turn off or disable voice controls on these devices while you are at Insights.

SOCIAL MEDIA AND APPS: I do not engage in communications or relationships with clients via social media. This is for your child's protection and to protect the therapeutic relationship. You and your child agree not to contact me on social media or apps. I will not accept "friend" requests or similar connections with clients, their family members or friends. Social media and apps are not private or confidential; and their use may disclose or interfere with our therapeutic relationship. I will not provide therapy by social media or apps, and I will not acknowledge or respond to private messages or client emergencies on social media or apps. Some social media and apps may seek to connect you or your child with me or other visitors to Insights through a "people you may know" or similar feature. If you want to minimize the risk of others becoming aware of your child's connection to me, it is your responsibility to make use of the privacy controls available on your and your child's social media and apps. If you would like to minimize the risk of others becoming aware of your or your child's physical location at Insights, it is your responsibility to make use of the location monitoring controls available on your and your child's smart devices.

YOU ACKNOWLEDGE YOU HAVE BEEN PROVIDED A COPY OF INSIGHTS' NOTICE OF PRIVACY PRACTICES. If you have any questions about confidentiality, let me know and we can discuss this further.

COMMUNICATION: During office hours, you or your child can reach me at 214.706.0508. I am normally not available after hours. From time to time we may communicate by telephone, text or email. I may charge my regular session rate for phone calls, text exchanges or email exchanges which exceed ten minutes. I may not receive or respond to telephone calls, texts or emails. The privacy and confidentiality (and exceptions to confidentiality) of telephone calls, texts and emails are identical to those of the privacy and confidentiality (and exceptions to confidentiality) of face-to-face sessions as stated in this Informed Consent to Treat. You understand that a telephone call, text or email may be disrupted due to technical difficulties or intercepted by an unauthorized party and may not be HIPAA-compliant.

EMERGENCIES: In case of emergency (an urgent issue requiring immediate action), you and your child should immediately contact 911, your physician, your local emergency room, the local police department or a crisis hotline. It is your responsibility to seek appropriate resources in emergency situations. Insights is not a crisis center; neither I nor Insights will be held responsible for any damages occurring as a result of an unmet crisis or acute care. In case of emergency, Insights is authorized (but not required) to discuss your emergency situation with the Emergency Contact listed in your New Client Information form.

PLAN FOR PRACTICE IN CASE OF DEATH OR INCAPACITY: In the event of my death, incapacity or disability, I have made arrangements for another therapist to take over my practice, assume control of my records, meet with clients, make appropriate referrals to other providers, if necessary, and take all reasonable steps to manage the practice for the benefit of my clients. By your signature below, you authorize my designee to contact you directly and use/disclose your child's confidential mental health information and records for the stated purposes.

TERMINATION: Normally we will terminate your child's therapy by mutual agreement but there are a few instances in which I may terminate our therapeutic relationship without your agreement. If I believe that my approach and training are no longer appropriate for your or your child's specific concerns or that your child is not benefitting from treatment, I will notify you of my decision to terminate the therapeutic relationship and give you referrals to other professionals who may be better suited to meet your child's needs. I understand that any termination may be difficult, but my decision on this matter will be final.

You have the right to terminate your child's therapy at any time. If you do not schedule an appointment within six (6) months of your child's last therapy session, you will be considered to have terminated therapy. As our therapy proceeds, I will assess the continued benefit of your child's therapy with me. I do not continue to treat clients who are not benefiting from therapy or those who believe I am unable to help. I will discuss this with you and, if appropriate, terminate treatment. In case of termination, I will provide you referrals to other therapists who may be of help to your child. If you request it and authorize it in writing, I will consult with the therapist you select to assist in your child's transition. Upon termination of therapy for any reason, the termination and referrals will be confirmed in writing.

COMPLAINTS: If you have a complaint or concern about your therapy, please speak first to me. If we are not able to resolve the complaint or concern, you may contact my licensing boards as follows: Texas State Board of Examiners of Professional Counselors; Texas State Board of Examiners of Marriage and Family Therapists; Licensed Chemical Dependency Counselor Program; Complaints Management and Investigative Section; P.O. Box 141369, Austin, Texas 78714-1369; 1.800.942.5540 (phone).

CONTACT INFORMATION: You consent for me and Insights to communicate with you and your child by mail, text, email, and phone at the addresses and phone numbers you provided on the New Client Information form, and you will IMMEDIATELY advise me if there is any change.

CONSENT TO TREAT: You have voluntarily agreed for your child to receive mental health assessment, care, or treatment, and you consent to and authorize me to provide such assessment, care, or treatment in the manner I consider necessary and advisable. You agree to participate in the planning of your child's care and treatment. By your signature to this Informed Consent to Treat, you confirm that you understand the nature of the proposed therapeutic treatment and you give your informed consent for your child to receive therapeutic services from me. By your signature below, you agree that this Informed Consent to Treat will stay in effect until you revoke it in writing and you acknowledge that this Informed Consent to Treat may be enforced as a written contract. You agree that a copy of this Informed Consent to Treat has the same force and effect as the original, and that any written revocation must be dated AFTER the date of this Informed Consent to Treat and must be provided to me before it will take effect.

REQUIRED DOCUMENTS (CHECK ONE):

□**PLEASE ATTACH COPIES OF ALL CUSTODY, CONSERVATORSHIP AND VISITATION AGREEMENTS, COURT ORDERS, AND DIVORCE DECREES CURRENTLY APPLICABLE TO THE CHILD.**

□**THERE ARE NO CUSTODY, CONSERVATORSHIP OR VISITATION AGREEMENTS, COURT ORDERS, OR DIVORCE DECREES CURRENTLY APPLICABLE TO THE CHILD.**

BY SIGNING THIS INFORMED CONSENT TO TREAT, YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTOOD ALL THE TERMS AND INFORMATION CONTAINED IN IT AND THAT AMPLE OPPORTUNITY HAS BEEN OFFERED TO YOU TO ASK QUESTIONS AND SEEK CLARIFICATION OF ANYTHING UNCLEAR TO YOU.

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Child's name printed or typed

_____

Parent or legal guardian signature Date