Wimberly Clinic: Guardian/Parent Informed Consent Agreement

Privacy and Confidentiality:

___I have had an opportunity to review the health care privacy and confidentiality policies, available at both the office site and at the business website, which are used by the providers at Virtue Medicine, P.C.

___I understand that the information the child shares with Dr. Wimberly in private sessions will be held confidential. However, the goals of the counseling may be shared with any legal custodial parent or guardian.

___I understand that the child's personal health information will be held in strictest confidence and will not be released without permission with the following exceptions: 1) a life-threatening medical emergency or public safety risk, and then only to persons to help reduce or prevent the threat, or 2) if there is suspicion that the minor is being or has been abused, 3) information is obtained in session that an elder or dependent adult is being or has been abused and 4) when required to do so by law or by legal proceedings.

Therapeutic Relationship:

___At the Virtue Medicine P.C. Clinics, I have the right to:

- Receive respectful and competent treatment within the provider's scope of practice.
- A safe treatment setting, free from sexual, physical, and emotional abuse.
- Report any immoral and illegal behavior by the provider.
- Request and receive information concerning my provider's qualifications, including licensing, education, training, experience, membership in professional groups, special areas of practice, and limits on practice.
- Request and receive written information concerning fees, methods of payment, insurance participation, course of treatment the provider believes will be needed, substitute health care providers (in cases of vacation and emergencies), and cancellation policies.

___I agree that health care with my provider is voluntary and can be discontinued at any time. My provider also has the right to discontinue services immediately if she judges that a therapeutic relationship cannot be maintained. Notice of discontinued treatment will be provided in writing.

Appointments and Cancellations:

___*Appointments are a valuable resource*. Cancellation must occur through *phone notification* to Virtue Medicine P.C. Reception (319-338-5190) at least 24 hours in advance; Monday appointments must be cancelled by 5 p.m. (Central) of the preceding Friday. If there is a missed appointment without the 24 hour cancellation, I understand that I will be billed for the full amount of the scheduled visit.

Payment:

___I understand that the provider's clinic is a fee-for-service practice and payments for service are due in full at the time of scheduling. If phone/email consultations or paperwork are requested other than during scheduled appointments, time spent in service will be billed to me in accordance with the fee schedule.

Telephone/Email Contacts and Emergencies:

___I understand that my private email is not a secure form of communication and that email is not necessary to my care plan at Virtue Medicine P.C. If I or my child in counseling initiates an email to the provider or to Virtue Medicine Reception, I understand that I am authorizing the use of this mode of communication for providing medical information and accept the liabilities entailed with this form of communication. If I do not wish to accept the liabilities of email, I and/or my child will not use that mode of communication.

___I understand that if I leave a message by phone/email for my provider that requires a response, I may expect a return message within 48 hours of her daytime clinic hours, which are posted. If my provider is on leave, directions on coordinating needs through the reception staff will be provided. Messages left for Virtue Medicine Reception will be returned within one business day, Monday through Friday, excepting holidays.

___I understand that Virtue Medicine P.C. have consulting care practices, not primary care practices, and there are no after-hour service options or 24-hour access. I understand that I am responsible for having a primary care physician who is aware of my health care and medications and can be contacted with medical emergencies. I understand that any *urgent or emergent assistance for health issues can be found at:* **911 or the local emergency room**. I agree that in an emergency with my child, I will call 911 or seek attention at my nearest emergency room.

___I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

___ Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

___ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant.

___ I am the legal guardian of the child noted below, and I give consent for Cynthia Wimberly, PhD, LPC-S to provide counseling services to the child. This consent is valid until termination of the therapeutic relationship.

I understand the information stated in this form and give consent for my child(ren) -

_____ to receive counseling services.

Parent/Guardian Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

Therapist Signature _____ Date_____

Wimberly Clinic: **Adolescent** Informed Consent Agreement

What to expect:

The purpose of meeting with a counselor or therapist is to get help with problems in your life that are bothering you or that are interfering with you being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you since the process of therapy involves getting to know your perspective.

Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling. However, as a teenager, you have certain rights to privacy that are not equal to those of an adult (the legal definition of which is 18 years old). ***As a general rule, information you share in therapy sessions is confidential, unless you give consent to disclose certain information.***

There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.
- You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person who you intend to harm.
- You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- You tell me you are being abused-physically, sexually or emotionally-or that you have been abused in the past. In this situation, I am required by law to report the abuse to the Department of Human Services or its equivalent in the state in which you reside.
- You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

Communicating with your parent(s) or guardian(s):

Except for situations such as those mentioned above, I will not tell your parent/guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

Also, parents and guardians may be able to be more helpful if they have general ideas about themes of therapy (such as autonomy, important privileges, achievement, or the status of symptoms) and the therapist may have specific suggestions for parents that do not involve breaking your privacy. Parents are strongly urged to respect the privacy of your treatment and the related records.

You should also know that it may be by law in your state of residence that your parent/guardian has the right to see any written records I keep about our sessions. It is extremely rare that a parent/guardian would ever request to look at these records.

Communicating with other adults:

School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor's Signature _____ Date_____