

Informed Consent & Confidentiality Agreement to Treat a Minor

Therapy involves a professional agreement between us. Because you are responsible for your child, I have included a list of basic guidelines and some important information that I ask you to follow in order to facilitate our harmonious work together.

First of all, the "therapeutic hour" is a 50-minute session. Payment for therapy is due at the time of service unless other arrangements have been made with me. Your fee shall be agreed upon by you and I and subject to revision as per mutual agreement.

If for some reason you are unable to keep your scheduled appointment, I would appreciate the courtesy of twenty-four hours notice, otherwise you will be charged your customary fee for that session, barring emergencies of course.

I would be happy to respond to any questions or needs you might have about your child, in between visits and during my normal working hours. I check my voice mail several times throughout the day and will return your call as soon as possible. However, if your child should have a mental health emergency and are unable to reach me, please call 911.

All statements made during counseling sessions are confidential and professional judgment will be used when considering sharing with what your child says in session. This information cannot be shared with others, except with a licensed supervisor or in a professional consultation. The exceptions to this rule would be if:

1. You have signed an authorization allowing me to disclose information;
2. Your child is in present danger of harming him/herself, another, or others;
3. Your child is in court ordered therapy; or the records are petitioned by court;
4. There is an issue of child, elder, or dependent adult abuse.

I, _____, the legal guardian or parent of _____,

agree to these conditions and do hereby give permission to Tarra Judson Stariell, MFT

to administer psychotherapy treatment to: _____
Name of Minor (Please Print)

Name of Parent or Guardian

Signature of Parent/Guardian

Date

Signature of Parent/Guardian

Date

Signature of Therapist

Date

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