CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES; CONFIDENTIALITY STATEMENT; & PAYMENT AGREEMENT

Minor Client Form

Child's name: _____

I, _____, consent to receive psychotherapy, psychological testing, or other professional services for my child from my clinician at Standard of Care Psychological Services, LLC. I understand that all information disclosed by me or my child in therapy or during testing is maintained in strict confidence and that documents pertaining to my child's treatment will not be released to others parties without my consent, except when mandated by law (such as suspected child or elderly abuse, serious intent to physically harm myself or another person). I further understand that there may be other conditions (such as a court order) that may place limits on the therapist's legal ability to maintain my child's confidentiality.

It is my expectation that I will be made aware of my child's progress in non-specific terms, but I understand that I will not be informed of specific details of what is discussed in therapy. However, I do expect that the therapist will inform me of any serious health or safety issues of which my child may be at risk, with the understanding that this determination will be made by the therapist.

I understand that if pre-arranged with my child's clinician, insurance claims may be filed on my child's behalf. Unless alternative payment arrangements have been made prior to the delivery of services, I understand that payment is due at the time services are delivered.

I understand that psychological testing reports will not be released until payment for the evaluation is made in full. I understand that I will be charged full psychotherapy or psychological testing fees and I agree to pay those fees in the event that I fail to show for an appointment or cancel an appointment with less than twenty-four hours notice. I understand that repeated late cancellations or failure to show for scheduled appointments may result in the termination of my child as a client.

I understand that my clinician will return any phone calls as soon as possible. However, if I experience an emergency situation and need to contact someone immediately to help me, I have been provided with the following numbers:

Emergency Services: 911
BHL (GA 24/7 Crisis Line) 1-800-715-4225
Peachford Hospital Assessment Center: (770) 454-2302
Ridgeview Institute Access Center: (770) 434-4568 Ext. 3200

My signature below indicates that I have read, been advised of, and understand the above information and that I give consent for my child to receive psychological services under these conditions. I also acknowledge that I have read and understand the HIPAA Georgia Notice Form. I also acknowledge that all offices have security cameras installed, subject to all confidentiality agreements contained herein.

Signature of Parent or Legal Guardian: _____ **Date:** _____

3910 Cascade Road, Suite T-90, Atlanta, GA 30331

Phone: 678.973.2491 | Fax: 404.745.8485