



# Strong Sense of Self Family Counseling Inc.

Vanessa Cardin, MA, LMFT

Licensed Marriage & Family Therapist #128077

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## **AGREEMENT FOR SERVICE / INFORMED CONSENT FOR MINORS**

### **Introduction**

This Agreement has been created for the purpose of outlining the terms and conditions of services to be provided by Vanessa Cardin for the minor child(ren) (herein "Patient") and is intended to provide [name of parent(s)/legal guardian(s)] (herein "Representative(s)") with important information regarding the practices, policies and procedures of Vanessa Cardin (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

### **Therapist Background and Qualifications**

Vanessa Cardin, M.A. is a Licensed Marriage and Family Therapist in Orange County. She works with individuals, couples, families and teens. Vanessa is trained in Eye Movement Desensitization and Reprocessing Therapy (EMDR), which is the leading approach for PTSD and those suffering from traumatic events. She is also Prepared and Enriched certified and is a member of California Association of Marriage and Family Therapist (CAMFT). Vanessa received a Masters Degree in Marriage and Family Therapy at Hope International University in 2017 and a Bachelor's Degree in Interpersonal Communication at Vanguard University in 2014.

In addition Vanessa is the Director of Sponsorship and sits on the board for Orange County California Association of Marriage & Family Therapist (OC-CAMFT), and Training Facilitator at Bloom Foundation. Vanessa is a Licensed Marriage & Family Therapist #128077 with the State of California, Board of Behavioral Sciences

### **Policy Regarding Consent for the Treatment of a Minor Child**

Therapist generally require the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of Representative to give consent for psychotherapy, Therapist will require that Representative submit supporting legal documentation, such as a custody order, prior to the commencement of services.

### **Risks and Benefits of Therapy**

A minor patient will benefit most from psychotherapy when his/her parents, guardians or other caregivers are supportive of the therapeutic process. Psychotherapy is a process in which Therapist and Patient, and sometimes other family members, discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as

well as, any problems or difficulties Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, as well as his/her caregivers and/or family members, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. This discomfort may also extend to other family members, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge the perceptions and assumptions of the Patient or other family members, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships.

During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Patient should address any concerns he/she has regarding his/her progress in therapy with Therapist.

### **Records and Record Keeping**

Therapist may take notes during session, and will also produce other notes and records regarding Patient's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any patient. Should Patient request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Therapist will maintain Patient's records for ten years following termination of therapy. However, after ten years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

### **Confidentiality**

The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult physical/sexual/neglect/emotional abuse, viewing and distributing (including sexting

with/involving minors) child pornography, and when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.

Representative should be aware that Therapist is not a conduit of information from Patient. Psychotherapy can only be effective if there is a trusting and confidential relationship between Therapist and Patient. Although Representative can expect to be kept up to date as to Patient's progress in therapy, he/she will typically not be privy to detailed discussions between Therapist and Patient. However, Representative can expect to be informed in the event of any serious concerns Therapist might have regarding the safety or well-being of Patient, including suicidality.

### **Patient Litigation**

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient and another individual, or entity, are parties. Therapist has a policy of not communicating with Patient's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Patient agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary hourly rate of \$300.

In addition, Therapist will not make any recommendation as to custody or visitation regarding Patient. Therapist will make efforts to be uninvolved in any custody dispute between Patient's parents.

### **Psychotherapist-Patient Privilege**

The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by a person with the authority to waive the privilege on Patient's behalf. When a patient is a minor child, the holder of the psychotherapist-patient privilege is either the minor, a court appointed guardian, or minor's counsel. Parents typically do not have the authority to waive the psychotherapist-patient privilege for their minor children, unless given such authority by a court of law. Representative is encouraged to discuss any concerns regarding the psychotherapist-patient privilege with his/her attorney.

Patient, or Representative, should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a

legal proceeding. Patient, or Representative, should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

### **Fee and Fee Arrangements**

The fee for individual service is \$160 per 50-minute session, EMDR service is \$165 per 50-minute session and Family/Couple service is \$165 per 50-minute session. Therapist reserves the right to periodically adjust this fee. Representatives will be notified of any fee adjustment in advance.

The agreed upon fee between Therapist and Representative is \$150. Therapist reserves the right to periodically adjust fees. Representatives will be notified of any fee adjustment in advance. From time-to-time, Therapists may engage in telephone contact with Patient or Representative for purposes other than scheduling sessions. Additional fee of \$45 will be charged for telephone conversations in excess of ten minutes, letters, reports and legal related matters. Representatives are expected to pay for services at the time services are rendered. Therapist accepts cash, checks (payable to "Strong Sense of Self Family Counseling"), and major credit cards.

### **Insurance**

Therapist does not bill insurance directly but will be happy to provide Patient with a monthly statement of services ("super bill") for Patient to submit to their insurance company. Payment is due at the time of service and Patient's insurance company will reimburse Patient according to Patient policy.

### **Cancellation Policy**

Representative is responsible for payment of the agreed upon fee for any missed session(s). Representative is also responsible for payment of the agreed upon fee for any session(s) for which Representative failed to give Therapist at least 24 hours notice of cancellation. Cancellation notice should be left on Therapist's voice mail at 949 930 9993. Please do not text.

### **Therapist Availability**

Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, Patient or Representative should call 911, or go to the nearest emergency room.

Therapist cannot guarantee that text messaging, email, and/or electronic receipts are secure or confidential forms of communication. Therefore, Therapist requests that the patient refrain from text messaging her, and use voice message and person to person phone calls for communication.

**Dual Relationships & Social Media**

Dual relationships can impair the therapeutic process, Therapist's objectivity, clinical judgment, or therapeutic effectiveness that could be exploitative in nature. Therapist will never acknowledge working therapeutically with anyone without his/her written permission. For this reason Therapist will not accept any invitations via social networking sites such as Facebook, Twitter, LinkedIn or Instagram with current or former Patients.

**Termination of Therapy**

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient or Representative has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient or Representative.

**Acknowledgement**

By signing below, the Representative acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Representative has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Representative's satisfaction. Representative agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, the Representative agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Signature of Patient (if Patient is 12 or older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Representative (and relationship to Patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Representative (and relationship to Patient)

\_\_\_\_\_  
Date

\_\_\_\_\_

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

\_\_\_\_\_  
Name of Responsible Party (Please print)

\_\_\_\_\_  
Signature of Responsible Party (and relationship to Patient)      \_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Responsible Party (Please print)

\_\_\_\_\_  
Signature of Responsible Party (and relationship to Patient)      \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Therapist      \_\_\_\_\_  
Date