

Let It Rain Psychotherapy, PLLC  
Sarah Billingsley, LMSW  
Supervised by Rayne Johnson, LCSW  
Parents Of Child or Teen – **Teen Support Group Initial forms**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Ethnicity: Check any/all that apply

\_\_\_\_\_Caucasian \_\_\_\_\_Black/African American \_\_\_\_\_Hispanic/Latino \_\_\_\_\_Native American

\_\_\_\_\_Asian/Pacific Islander \_\_\_\_\_Other: \_\_\_\_\_

Primary Address of Child/Teen: \_\_\_\_\_

Parents phone Numbers (Both): Mom \_\_\_\_\_ Dad \_\_\_\_\_

Email: \_\_\_\_\_

How does mom/dad want to be contacted: (circle one)      Phone Call      Email      Text

Can I leave a voicemail on cell? (circle one)    Yes      No

Can I text message appointment reminders: (circle one)    Yes      No

How did you hear about the Teen Support Group at Let It Rain Psychotherapy? (ex: Google, Psychology Today, Therapist, Friend/Family, etc.) \_\_\_\_\_

Child/Teen's Primary Physician: \_\_\_\_\_  
Name                      Address                      Phone Number

Child/Teen Psychiatrist: \_\_\_\_\_  
Name                      Address                      Phone Number

Emergency Contact:

\_\_\_\_\_  
Name                      Address                      Phone Number

Relationship to Emergency Contact: \_\_\_\_\_

By giving emergency contact and signing below, I give permission to Sarah Billingsley, LMSW to contact person listed in the event of an emergency.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Welcome.** The purpose of this informed consent to provide a teen support group your teen is to make you aware of important aspects of the support group process and have everyone involved understand and be in agreement from the outset. Parents of minors are required to read and sign this consent in order for your teen to become a client at Let It Rain Psychotherapy. Parents who are separated or divorced must provide me with any legal documents affecting their child(ren) and both parents must be present to sign this agreement at the first session or *alternate arrangements must be made with me* (and I am happy to offer accommodations, please call me) so that both parents consent in writing to your teen's therapy. If one of the parents is an absentee parent, I will provide documentation that you are required to sign related to the absenteeism of that parent before therapy with your teen can begin.

**What to expect:**

Initially, I will gather information from parent(s) about what you believe is troubling your teen, signs, symptoms, and what you hope your teen with accomplish in group. I will then gather information from your teen through an assessment. This assessment will help me better understand the topics which will be important to your teen in group.

During your teen's time in group she/he may gain support from other teens dealing with similar issues while I, the facilitator, will help to steer the conversation in a healthy manner. It is important to understand that this group is not a therapy group and should not be substituted for your child seeking an individual therapist. This group will educate your teen on specific topics and then allow for them to gain support from their peers. Your teen has the right to talk to you and me about their positive and negative feelings related to the group, and I commit to doing everything I can to make their experience a success. If at any point you feel my intervention is not working, please talk to me before pulling your child from group. If after talking to me about your thoughts and feelings, you still wish to end your teen's time in group, I can provide referrals to other groups and/or therapists at your request.

**Confidentiality**

What your teen discusses with me in the sessions is private and confidential. I will not tell you or anyone what your teen discusses in session, nor will I release your teen's record, without your teen's written consent or court subpoena. I will however, give you any diagnoses and education related to the diagnoses, updates on the general focus of work in group and your teens progress. Working with teens at times poses ethical dilemmas that require the consultation of other licensed professionals. Should I use consultation, the identity of your teen will be concealed, and only the dilemma will be discussed so that a decision about the intervention direction is made with the combined wisdom and experience of knowledgeable, skilled, professional therapists. There is one exception to this outlined in #5 of the section Exceptions to Confidentiality.

In order to facilitate a trusting and honest relationship with your teen, I will not violate their right to confidentiality. Honoring your teens right to confidentiality helps her/him feel safe to talk about and receive guidance related to problems and pressure common to most every teen. Your teen may confide information about their experiences and activities of which you may not approve. For example, getting a tattoo or experimenting with alcohol at a party. These kinds of issues are worked through during therapy sessions and, only if and when, in my professional judgement, these activities pose an imminent risk of harm or injuring will I help **the teen inform you**. This is the best way for your child to learn consequences, problem solve, and take responsibility for her/his actions. An example of a situation I would help your teen talk with you about would be if your teen reports she/he consumed alcohol at a party and then drove home intoxicated or got in the car with someone who was intoxicated, or if I believe your teen is addicted to alcohol or drugs. This kind of information will not be withheld from you.

I will also ask all of the teens in the group to follow the same rules for keeping what is said in group confidential. It is important to note though that I cannot 100% ensure that another teen will not repeat something outside of group. If this ever happens and I am notified, I will address the break in confidentiality with the client.

**Records**

Your teen's record is confidential and will not be shared with anyone. I do not allow parents to view the teen's record if I feel the teen will be harmed emotionally by my doing so. If you have concerns about what your teen is discussing in therapy sessions, please talk to me.

You will find that I keep you quite informed on what your teen is working on and do so without violating your teens confidence.

There are exceptions to your teens right to confidentiality and they are:

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**Exceptions to Confidentiality**

1. If your teen leads me to believe that she/he is planning to harm her/himself or commit suicide and I believe she/he has the means and serious intent to do so, I am obligated to inform teen's parent(s) or guardian(s) of this
2. If your teen leads me to believe she/he is seriously planning to harm or kill another person I am obligated by Texas law and the guidelines of my profession to report this to parent(s) or guardian(s) and the local authorities.
3. If your teen tells me that she/he or a child, elderly person, or person with disabilities was or is being physically or sexually abused, I am obligated by Texas law to report this to the Department of Family and Protective Services (CPS and/or APS).
4. If your teen's records are subpoenaed by the court or a judge, I am obligated by law to comply. I will inform you and your teen of the subpoena and will do all I can within the law to protect your teen's confidentiality.
5. It is also pertinent for you to know that I am a Licensed Master Social Worker under clinical supervision by Rayné Johnson, LCSW as I work towards my clinical licensure. This means I am required to review all of my client cases with her to ensure you are receiving ethical treatment within my areas of competency. There will be times when Rayné Johnson, LCSW must review your teen's records to ensure proper documentation and that I meet the standards of our profession as it relates to providing clinical care. *Feel free to discuss any questions or concerns you may have regarding this information with me at any time.*

**Cost of services**

Forms of payment accepted are cash, debit, and credit. A debit/credit card must remain on electronic file for your teen to be a client here. The fee is **\$25 per 50 minute group session, totaling \$150 for all 6 sessions** for teens *not* already a client of Let It Rain Psychotherapy, PLLC. The fee is **\$20 per 50 minute group session, totaling \$120 for all 6 sessions** for teens who *are* already a client of Let It Rain, Psychotherapy, PLLC. My fees for the *initial* one hour assessment is \$75 (included in the overall \$120/\$150 price). Then, on the day of the first group, the remaining \$45 for clients and \$75 for non-clients is due. In the assessment session, your teen will undergo a brief clinical assessment which will help us both understand any indication of depression as well as the main reasons your teen is needing this support group. This will help me direct our problem identification, goals and objectives, and then, later, the conclusion of our journey together.

Please see Electronic Payment Communications Disclosure form for additional information.

**Phone calls**

I am not able to be on call 24/7. Currently, when you call me and leave a voicemail. I will respond within 24 hours. If I am asked to call you between sessions to discuss issues related to your child/teen's group sessions, you will be charged a fee for that call. Calls initiated by you that require **psychotherapeutic consultation** will be prorated per 15-minute increments at the above costs: \$18.75 per 15 minutes to be paid at the end of the call.

**Cancellations**

I respectfully request *24 hours advanced notice* of your teen needs to miss a scheduled group appointment. *There are no refunds for groups already paid for.* Please keep this in mind if your teen misses a group session

**Emergency Contact**

I understand that emotional crises sometimes happen after hours. At this time, I am not able to be on-call 24 hours. If your teen has an emergency during the time I am not keeping office hours, after normal business hours, or if I am with other clients, you must call 911 or go to your nearest emergency room. Currently, when you call me and leave a voicemail. I will respond within 24 hours.

**Court Testimony**

I do not arrange to offer testimony in court. If you have me subpoenaed by a lawyer or judge and it cannot be quashed, you will be charged \$250 per hour with a 4-hour minimum plus a \$50 per day per diem. I also charge \$25 for copies of any subpoenaed records and \$.50 per mile for travel. Please know that I do not make recommendations to the court as to where your teen should live or speak on the character or abilities, or lack there-of, of the other parent. Minimum payment for this service is expected at least one week PRIOR to the scheduled court date and will be charged to the credit/debit card on file. There are no credits or refunds. In conclusion...

Thank you for the opportunity to work with your teen. Signing below indicates that you have reviewed the policies described above, understand, and agree. If you have any questions as we progress with therapy, you can ask me at any time.

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Parent(s)/Guardian(s):

**Initial** boxes and sign below indicated your agreement to respect your adolescent's privacy:

/ \_\_\_\_\_ / I agree to allow my teen to receive group therapy from Sarah Billingsley, LMSW of Let It Rain Psychotherapy, PLLC.

/ \_\_\_\_\_ / I will refrain from requesting detailed information about group sessions with my teen. I understand that I will be provided with regular updates about general progress.

/ \_\_\_\_\_ / Although I know it is my right as a parent to request and receive my teen's record, I understand that Let It Rain Psychotherapy's policy is to disallow anyone to view my teens records. I understand that keeping my teen's record confidential helps her/him become more trusting of parents and therapist, and more willing to work hard in therapy sessions.

/ \_\_\_\_\_ / I understand that I will be informed about situations that could endanger my teen. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgements and may sometimes be made in confidential consultation with another licensed therapist.

By my signature below, I attest that I have read, understand and agree with this informed consent and give my full consent for my teen to receive therapy at Let It Rain Psychotherapy, PLLC with Sarah Billingsley, LMSW.

Parent Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date: \_\_\_\_\_

Minor's signature \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date: \_\_\_\_\_

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I am required by law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). I will follow the privacy practices that are described in this Notice. If I amend this Notice, I will provide you with the amended Notice for your information and signature.

For more information about my privacy practices, or for additional copies of this Notice, please let me know your questions as soon as they arise.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

**Permissible Uses and Disclosures Without My Written Authorization.** I may use and disclose your PHI without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures of your mental health information that are legally permissible.

**Treatment:** I may use and disclose your PHI to other clinicians involved in your care in order to better provide integrated treatment to you. For example, I may discuss your diagnosis and treatment plan with your psychiatrist or nurse practitioner. In addition, I may disclose your PHI to other health care providers in order to provide you with appropriate care and continued treatment.

**Payment:** I may use or disclose your PHI for the purposes of determining coverage, billing, claims management, and reimbursement. For example, a bill sent to your health insurer may include some information about our work together so that the insurer will pay for the treatment. I may also inform your health plan about a treatment you are going to receive in order to determine whether the plan will cover the treatment.

**Health Care Operations:** I may use and disclose your PHI in connection with health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities. For, example, I may disclose disguised information about our work for training purposes.

**Required or Permitted by Law:** I may use or disclose your PHI when I am required or permitted to do so by law. For example, I may disclose your PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. In addition, I may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access your PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; disclosures for workers' compensation claims, and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions as authorized by law.

Permissible Uses and Disclosures That May Be Made Without My Authorization, But For Which You Have An Opportunity to Object.

**Fundraising:** I may use your PHI to contact you in an effort to offer you new services. I may also disclose PHI to any foundation with which I am connected so that the foundation may contact you in an effort to raise money for its operations. Any fundraising communications with you will include a description of how you may opt out of receiving any further fundraising communications.

**Family and Other Persons Involved in Your Care.** I may use or disclose your PHI to notify, or assist in the notification of (including identifying or locating) your personal representative, or another person responsible for your care, location, general condition, or death. If you are present, then I will provide you with an opportunity to object prior to such uses or disclosures. In the event of your incapacity or emergency circumstances, I will disclose your PHI consistent with your prior expressed preference, and in your best interest as determined by my professional judgment. I will also use my professional judgment and my experience to make reasonable inferences of your best interest in allowing another person access to your PHI regarding your treatment with me.

**Disaster Relief Efforts.** I may use or disclose your PHI to a public or private entity authorized by law or its charter to assist in disaster relief efforts for the purpose of coordinating notification of family members of your location, general condition, or death.

Uses and Disclosures Requiring Your Written Authorization.

**Psychotherapy Notes.** I will not disclose the records of our work that I keep separate from the medical record for my personal use, known as psychotherapy notes, except as permitted by law.

**Marketing Communications; Sale of PHI.** I must obtain your written authorization prior to using or disclosing your PHI for marketing or the sale of your PHI, consistent with the related definitions and exceptions set forth in HIPAA.

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Other Uses and Disclosures. Uses and disclosures other than those described in this Notice will only be made with your written authorization. For example, you will need to sign an authorization form before I can send your PHI to your life insurance company or to your attorney. You may revoke any such authorization at any time by providing me with written notification of such revocation.

MY INDIVIDUAL RIGHTS

Right to Inspect and Copy. You may request access to your medical records and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested.

Right to Alternative Communications. You may request, and I will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

Right to Request Restrictions. You have the right to request a restriction on your PHI that I use or disclose for treatment, payment or health care operations. You must request any such restriction in writing addressed to Rayne Johnson, LCSW. I am not required to agree to any such restriction you may request, except if your request is to restrict disclosing your PHI to a health plan for the purpose of carrying out payment or health care operations, the disclosure is not otherwise required by law, and the PHI pertains solely to a health care item or service which has been paid in full by you or another person or entity on your behalf.

Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of disclosures of your PHI made by me in the last six years, subject to certain restrictions and limitations.

Right to Request Amendment: You have the right to request that I amend your PHI. Your request must be in writing, and should explain why the information should be amended. I may deny your request under certain circumstances.

Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to Rayné Johnson, LCSW at any time.

Right to Receive Notification of a Breach. I am required to notify you if I discover a breach of your unsecured PHI, according to requirements under federal law.

Questions and Complaints. If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, please contact me at 817-874-8169. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint.

EFFECTIVE DATE AND CHANGES TO THIS NOTICE

Effective Date. This Notice is effective on September 2013.

Changes to this Notice. I may change the terms of this Notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in the waiting area of my office and on my website at [www.let-it-rain.org](http://www.let-it-rain.org). You may also obtain any revised notice by asking me directly.

This is your copy. Please sign the following page.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge that I received a copy of Rayné Johnson, LCSW's Notice of Privacy Practices.

Printed name of client \_\_\_\_\_

Signature of client \_\_\_\_\_ Date \_\_\_\_\_

Signature of LMSW \_\_\_\_\_ Date \_\_\_\_\_

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign \_\_\_\_\_
- Communications barriers prohibited obtaining the acknowledgement \_\_\_\_\_
- An emergency situation prevented us from obtaining acknowledgement \_\_\_\_\_
- Other( Please Specify) \_\_\_\_\_

**This form will be retained in your medical record**

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**Consent to Communicate Electronically**

Communication between sessions is sometimes necessary. The most secure way to communicate so that your confidentiality is protected is by way of phone calls. Text messaging is the next most secure way of communication because my cell phone is password protected. The least secure way of communicating with me is through email. My email is a regular email account through Google. The risk of destroyed privacy is high when using email. Email sent between you and I could be hacked, intercepted, and dispersed to others.

By signing below, you indicate that you have read, and understand, and agree with the above notice of risk. By initialing by your preference(s), you indicate the method of contact for which you give permission.

My therapist has:

\_\_\_\_\_ Permission to call my cell.

\_\_\_\_\_ Permission to leave voicemail.

\_\_\_\_\_ Permission to respond to email from me.

\_\_\_\_\_ Permission to contact me via text.

\_\_\_\_\_ Permission to contact me via email.

\_\_\_\_\_ Do not contact me by any of the above means *except by phone call*.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Child/Teens Name: \_\_\_\_\_

**ELECTRONIC PAYMENT COMMUNICATIONS DISCLOSURE**

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If you wish, you may pay fees electronically – through funds transfer or using a payment card -- using any of the following services:

- *Cayan or TSYS*

**Please Be Aware of the Following:**

We have a duty to uphold your confidentiality, and thus we wish to make sure that your use of the above payment services is done as securely and privately as possible.

After using any of the above services to pay your fees, that service may send you receipts for payment by email or text message. These receipts will include our business name and would indicate that you have paid for a therapy session.

It is possible the receipt may be sent automatically, without first asking if you wish to receive the receipt. We are unable to control this in many cases, and we may not be able to control which email address or phone number your receipt is sent to.

So before using one of the above services to pay for your session(s), please think about these questions:

- At which email address or phone numbers have I received these kinds of receipts before?
- Are any of those addresses or phone numbers provided by my employer or school? If so, the employer or school will most likely be able to view the receipts that are sent to you.
- Are there any other parties with access to these addresses or phone numbers that should not be seeing these receipts? Would there be any danger if such a person discovered them?
- Is it better for me to pay cash to avoid these risks all together?

In addition to these possible emails or text messages, payments made by credit card will appear on your credit card statement as being made to *Let It Rain Psychotherapy PLLC*. Please consider who might have access to your statements before making payments by credit or debit card.

*I have read, understand, and agree with the above risks of paying electronically by using Cayan/TSYS and I know I have the option of paying by cash.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Child's/Teen's Name: \_\_\_\_\_