Let It Rain Psychotherapy, PLLC
Rayné Ventimiglia, LCSW-S
Informed Consent for
Parents of Teens

Welcome. The purpose of this informed consent to provide psychotherapy for your teen is to make you aware of important aspects of the therapeutic 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 us a copy of 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 us (*and we am happy to offer accommodations, please call us) so that both parents consent in writing to your teen's therapy. If one of the parents is an absentee parent, we 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 we will gather information from parent(s) about what you believe is troubling your teen, signs and symptoms of mood problems and other disorders, and what you hope your teen will accomplish in therapy. We will then gather information from your teen. Over the first two to three session we will assess and make a treatment plan that includes the therapeutic modality and collaborated goals and objectives. Parent(s) will be informed of the treatment plan and given the opportunity to voice issues or concerns.

Teens often demonstrate resistance, fear, or grief related to receiving therapy although some look forward to it. These reactions are normal. In session your teen is given the opportunity to do most of the talking. we listen carefully and ask questions to help guide your teen into exploration and discovery of underlying issues and possible solutions to what troubles them. We also help them identify discrepancies between their desires and the behavior getting in the way of the life they really want. Helping your teen increase positive feelings and behaviors is a process that is most successful when therapist and teen collaborate on problem identification, goals, objectives, and solutions.

During your teen's time in therapy she/he may experience feelings of sadness, anger, and anxiety. This is a normal part of the therapeutic process. Your teen has the right to talk to you and us about their positive and negative feelings related to treatment, and we commit to doing everything we can to make their therapy a success. we use cognitive behavioral therapy in combination with other modalities of therapy we believe are most beneficial for the

issues your teen is facing. If at any point you feel my therapeutic intervention is not working, please talk to us before stopping therapy. If after talking to us about your thoughts and feelings you still wish to end your teen's therapy we can provide referrals to other therapists at your request.

Confidentiality:

What your teen discusses with us in session is private and confidential. We will not tell you or anyone outside this office what your teen discusses in session, nor will we release your teen's record without your teen's written consent or court subpoena. We will however, give you any diagnoses and education related to the diagnoses, updates on the general focus of work in session, progress, and the plan for moving the therapeutic process forward. Working with teens at times poses ethical dilemmas that require the consultation of other licensed therapists. Should we 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.

In order to facilitate a trusting and honest relationship with your teen, we will not violate their right to confidentiality. Honoring your teen's 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 injury will we 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 we 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 we believe your teen is addicted to alcohol or drugs. This kind of information will not be withheld from you.

Records

Your teen's record is confidential and will not be shared with anyone outside this office. We do not allow parents to view the teen's record if we 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 us. You will find that we keep you quite informed on what your teen is working on and do so without violating your teens confidence.

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There are exceptions to your teen's right to confidentiality and they are:

Exceptions to Confidentiality

1. If your teen leads us to believe that she/he is planning to harm her/himself or commit suicide and we believe she/he has the means and serious intent to do so, we am obligated to inform teen's parent(s) or guardian(s) of this.
2. If your teen leads us to believe she/he is seriously planning to harm or kill another person we 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 us that she/he or a child, elderly person, or person with disabilities was or is being physically or sexually abused, we 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, we am obligated by law to comply. we will inform you and your teen of the subpoena and will do all we can within the law to protect your teen's confidentiality.

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. Fees for the *initial* one hour assessment is ***$150.*** In the first session your teen will undergo a clinical assessment which will help us both understand any clinical presentation (diagnoses) she or he has and will direct our problem identification, goals and objectives, intervention, and then, later, the conclusion of our journey together. *After* the initial visit, the fee is ***$125 per 50 minute session.*** *For* ***family counseling my fee is $150 with or without your teen.*** You can expect to have at least one family therapy session during the course of treatment. **Your insurance may not cover family sessions and it is your responsibility to know whether you will be responsible for the balance.** There is a number on the back of your insurance card to call and check. Insurance accepted is limited to BCBSTX and Medicare and Traditional Medicaid at this time. If you have another insurance and would like to use out-of-network benefits, at your request you are given a receipt to file your own insurance. ***If, when we file your claim the insurance company refuses to pay for any reason, you are responsible for the amount not paid by your insurance.***

Please see *Services and Fees Form* for additional information.

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Phone Calls

If we are asked to call you between sessions to discuss issues related to your child/teen's therapy, 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: $31.25 per 15 minutes to be paid at the end of the call.

Cancelations

We respectfully request 24 hours advanced notice of your need to cancel a scheduled appointment. ***Notice of cancelation less than 24 hours will result in your being charged that day for the full amount of the missed session. There is a $50 no show fee/late cancellation for the initial session.*** There are some exceptions: if Grapevine-Colleyville school district cancels school for snowy/icy road conditions; if your child/teen has a medical emergency **requiring hospitalization**; if there is a death in the immediate family. Under these conditions you will not be charged. *Illness is not in these exceptions.*

Emergency Contact

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

Court Testimony

We do not arrange to offer testimony in court. If you have us subpoenaed by a lawyer or judge and it cannot be quashed, you will be charged $350 per hour with a 4 hour minimum plus a $50 per day per diem. We also charge $25 for copies of any subpoenaed records and $.50 mile for travel. Please know that we 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.

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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 us at any time.

Parent(s)/Guardian:
Initial boxes and sign below indicating your agreement to respect your adolescent's privacy:

/_/ we agree to allow my teen to receive psychotherapy from Rayné Ventimiglia, LCSW-S, LCSW of Let it Rain Psychotherapy, PLLC.

/__/ we will refrain from requesting detailed information about individual therapy sessions with my teen. we understand that we will be provided with regular updates about general progress, and/or may be asked to participate in therapy sessions as appropriate.

/__/ Although we know it is my right as a parent to request and receive my teen's record, we understand that Let It Rain Psychotherapy's policy is to disallow anyone to view my teens records. we understand 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.

/__/ we understand that we will be informed about situations that could endanger my teen. we 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 another licensed therapist.

By my signature below we attest that we 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:

Parent Signature ____ Date____________

Parent Signature ____ Date____________

Minor's Signature _______________________________________ Date____________

Therapist Signature ______________________________________ Date____________

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Rayne Ventimiglia, LCSW-S
Let It Rain Psychotherapy, PLLC
7165 Colleyville Blvd. Ste. 102 Colleyville TX 76034

NOTICE OF PRIVACY PRACTICES

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.

we am required by law to maintain the privacy of your health information. we 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"). we will follow the privacy practices that are described in this Notice. If we amend this Notice, we 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 us know your questions as soon as they arise.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Permissible Uses and Disclosures Without My Written Authorization. we 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: we may use and disclose your PHI to other clinicians involved in your care in order to better provide integrated treatment to you. For example, we may discuss your diagnosis and treatment plan with your psychiatrist or nurse practitioner. In addition, we may disclose your PHI to other health care providers in order to provide you with appropriate care and continued treatment.

Payment: we 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. we 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: we 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, we may disclose disguised information about our work for training purposes.

Required or Permitted by Law: we may use or disclose your PHI when we am required or permitted to do so by law. For example, we may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. In addition we 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: we may use your PHI to contact you in an effort to offer you new services. we may also disclose PHI to any foundation with which we 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. we 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 we will provide you with an opportunity to object prior to such uses or disclosures. In

the event of your incapacity or emergency circumstances, we will disclose your PHI consistent with your prior expressed preference, and in your best interest as determined by my professional judgment. we 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 us.

Disaster Relief Efforts. we 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.

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1901 Central Dr. Ste. 812 Bedford, TX 76021

NOTICE OF PRIVACY PRACTICES

Uses and Disclosures Requiring Your Written Authorization.

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

Marketing Communications; Sale of PHI. we 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.

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 we can send your PHI to your life insurance company or to your attorney. You may revoke any such authorization at any time by providing us 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 us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records. we may charge a fee for the costs of copying and sending you any records requested.

Right to Alternative Communications. You may request, and we 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 we use or disclose for treatment, payment or health care operations. You must request any such restriction in writing addressed to Rayné Ventimiglia, LCSW-S, LCSW. we 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 us in the last six years, subject to certain restrictions and limitations.

Right to Request Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and should explain why the information should be amended. we 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 Ventimiglia, LCSW-S, LCSW at any time.

Right to Receive Notification of a Breach. we am required to notify you if we 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 we have violated your privacy rights, please contact us 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. we 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. we may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in the waiting area of my office and on my website at www.let-it-rain.org. You may also obtain any revised notice by asking us 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 we acknowledge that we received a copy of Rayné Ventimiglia, LCSW-S, LCSW's Notice of Privacy Practices.

Printed name ____

Signature ____Date____________________

Signature of LCSW ____ 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

we 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