Informed Consent, Responsibilities and Policies

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

**Psychological Services**

Psychotherapy varies depending on the personalities of the psychologist and client, and the concerns that are being addressed. There are many different methods I may use to deal with presenting concerns. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on you and your child’s part.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of life, your child may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have benefits, but there are no guarantees as to what your child will experience.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my approach or methods, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you find another mental health professional.

**Coordination with Primary Care**

I believe it is important to coordinate care with your child’s physician. Both federal and state privacy laws encourage this coordination between health care providers. I try to share only the minimal amount of information necessary to coordinate care. Please inform me if you do NOT want me to coordinate care with your child’s physician.

**Cancellations and No-Shows**

I require a 24-hour advance notice for cancellations or re-schedules. A late cancellation or a no-show has an impact. If I have enough notice of a cancellation, I can provide help to someone else. A late cancellation or no-show means that I am unable to serve another person. As a result, I charge a $70 fee for a no-show or late cancellation (less than 24- hours notice). This fee is not covered by insurance and is due by the next appointment. If you have no-showed and have not rescheduled an appointment after 60 days, I will assume your child is ending treatment and I may close the file at that time. Also keep in mind if you need to cancel an appointment with less than 24- hours notice because your child cannot attend, I can usually change an appointment from an individual session with the child to a parent only session. We can use the session to check in about your child’s progress in treatment and discuss current concerns. This will allow you to keep the appointment and prevent you from incurring a late cancellation fee.

If your child wakes up in the morning and is sick on the day of an appointment, please call me right away and let me know. I will typically waive the late cancelation fee for illness if I get a call before 9am. Calling me first thing in the morning allows me time to contact someone on my wait list. Please do not bring your child to session if they are ill. In general, if your child is too sick to go to school, they should...
not attend a therapy appointment. In addition, if your child has lice please do not bring them to an
appointment until they are free of lice and nits. Please help me keep my office a safe and healthy place.

**Telephone Communication**

I am often not immediately available by telephone. Though I am usually in my office approximately
between 9:00 AM and 5:00 PM Monday-Friday, I will not answer the phone when I am with a client.
When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make
every effort to return your call within 24 hours, with the exception of weekends, holidays or a day that I
am not in the office. If you are difficult to reach, please inform me of some times when you will be
available.

**Electronic Communication**

I use email with your permission for administrative purposes unless we have made another agreement.
That means email messages with my office should be limited to things like setting and changing
appointments, billing matters and other related issues. Please do not email me about clinical matters
because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please
feel free to call me so we can discuss it over the phone or wait so we can discuss it during a session. The
telephone or face-to-face is simply a much more secure mode of communication. I send out automated
email appointment reminders, if you do not want to receive these reminders please let me know. Email
reminders are a courtesy, you are responsible for remembering and attending appointments even if you do
not receive a reminder email.

Because text messaging is a very unsecure and impersonal mode of communication, I do not text message
clients nor do I respond to text messages from anyone in treatment with me.

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and
Facebook. I participate on various social networks, but not in my professional capacity. If you have an
online presence, there is a possibility that you may encounter me by accident. I believe that
communication with clients and their family members online has a high potential to compromise the
professional relationship. Please do not try to contact me in this way.

**Crisis and Emergencies**

If your child is experiencing a mental health emergency and it is during business hours (typically
Monday- Friday 9:00am-5pm) please contact my office. If I am not available, please leave a message on
my confidential voicemail and I will call you back as soon as possible. If you are unable to reach me and
feel that you cannot wait for me to return your call, contact your child’s physician, go to the nearest
emergency room, call 911, or contact the Multnomah County Crisis Line at (503) 988-4888.

**Professional fees and Use of Insurance**

My fee is $225 per session and sessions typically are 45-50 minutes in length. In addition to weekly
appointments, I charge this same hourly rate for other professional services you may need. Other
professional services may include report writing, letter writing, telephone conversations lasting longer than
10 minutes, attendance at meetings with other professionals you have authorized, and the time spent
performing any other service you may request of me. If you become involved in legal proceedings that
require my participation, you will be expected to pay for any professional time I spend on your legal matter,
Christina Irvine, PsyD  
Licensed Psychologist  

even if the request comes from another party. I charge $250 per hour for professional services I am asked or required to perform in relation to your legal matter.

If your account balance has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency.

If you are utilizing health insurance you are responsible for any co-pay, co-insurance or deductible amounts. It is also your responsibility to let me know if there is any change in your child’s insurance or coverage. You are responsible for any fees refused or unauthorized by your insurance plan. All copays, co-insurance, and session fees not covered by insurance are due at the time of service. If there is a balance due on your account I ask that you make a payment within 30 days of being notified of the amount due.

You should also be aware that most insurance companies require that I provide them with your child’s clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. I will provide you with a copy of any records I submit, if you request it. You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.

**Parent Authorization for Minor’s Mental Health Treatment**

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child’s other parent, please be aware that it is my policy to communicate with the other parent. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child’s treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements, or we can agree to disagree, so long as this enables your child’s therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

**Confidentiality**

**Individual Parent/Guardian Communications**

In the course of my treatment of your child, I may meet with the child’s parents/guardians either separately or together. Please be aware, however, that at all times, my client is your child – not the parents/guardians nor any siblings or other family members of the child.

If I meet with you or other family members in the course of your child’s treatment, I will make notes of that meeting in your child’s treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child’s treatment record.
Mandatory Disclosures

As a mandated reporter, if I believe an individual has been the victim of abuse, neglect or has witnessed domestic violence, I may disclose protected health information to the appropriate government authority. This includes children, persons who have a mental health diagnosis and the elderly.

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have you or your child’s permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child clients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be.
- Child clients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm and/or the police.
- Child clients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- Child clients tell me, or I otherwise learn that, it appears that a child is being neglected or abused—physically, sexually or emotionally—or that it appears that they have been neglected or abused in the past. In this situation, I may be required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

Disclosure of Minor’s Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the psychologist and the client. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a “zone of privacy” where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child’s treatment, but not to share specific information your child has disclosed to me without your child’s agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child’s risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

Example: If your child tells me that he/she has tried alcohol at a few parties, I would keep this information confidential. If your child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential.
from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.

**Example:** If your child tells me that he/she is having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of “hypothetical situations,” such as: “If a child told you that he or she were doing ________, would you tell the parents?”

Even when we have agreed to keep your child’s treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child’s life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child’s problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

**Disclosure of Minor’s Treatment Records to Parents**

Although the laws of Oregon may give parents the right to see any written records I keep about your child’s treatment, by signing this agreement, you are agreeing that your child or teen should have a “zone of privacy” in their meetings with me, and you agree not to request access to your child’s written treatment records.

**Parent/Guardian Agreement Not to Use Minor’s Therapy Information/Records in Custody Litigation**

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child’s parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither parent will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent’s custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $250 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.
Parent/Guardian of Minor:
Please initial after each line indicating your agreement to respect your child’s privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about progress, and/or may be asked to participate in therapy sessions as needed.


Although I may have the legal right to request written records/session notes since my child is a minor, I agree not to request these records in order to respect the confidentiality of my child’s/adolescent’s treatment.


I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist’s professional judgment, unless otherwise noted above.


Thank you for taking the time to read through some of the fine print. Discussing some of these concerns at the beginning of treatment helps us to start out on the right foot. Please be sure to let me know if you have any questions or concerns. I look forward to working with you and your child.

I acknowledge that I have read the information presented in the Informed Consent, Responsibilities and Policies form.

_________________________________________  ____________
Parent Signature  Date

_________________________________________
Printed Name

_________________________________________  ____________
Parent Signature  Date

_________________________________________
Printed Name

_________________________________________  ____________
Client Signature  (14 years and older)  Date

_________________________________________
Printed Name