

Will Joel Friedman, Ph.D.

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Information, Informed Consent & Confidentiality With Minor Children and In Divorces

Informed Consent: Therapy may involve the risk of remembering unpleasant events and can arouse intense emotions of fear and anger. Intense feelings of anxiety, depression, frustration, loneliness, or helplessness can also be aroused at times. No one can predict the course of human relationships, and that it may be necessary to amend prior agreements as the psychologist and participants learn more about each other. All children are entitled to developmentally appropriate information about their treatment, including limits to confidentiality and appropriate participation in making decisions about their treatment. Children have the same confidentiality rights as adults. Psychologist may elect to not treat parent as legal representative if they have reasonable belief that child may be/has been subject to abuse, neglect or willful cruelty, or doing so would endanger the child. The psychologist decides, through exercise of professional judgment, it is not in child's best interest to do so.

The benefits from psychotherapy may be that you will be better able to handle or cope with your family or other social relationships, thus experiencing more satisfaction from those relationships. Another possible benefit may be a better understanding of your personal goals and values; this may lead to greater maturity and growth as a person. A psychologist is not a medical physician and cannot prescribe or provide you with any medications at this current time. If needed, I can recommend a psychiatrist or primary care physician, or you can find one.

If it is my professional judgment that the minor child (or children) is at serious risk of doing harm or killing him- or herself, my only treatment goal is to keep him or her safe and alive. I will do whatever I need to do to protect him or her to include notifying and involving members of your family or people you are closest to. If this is unacceptable to you, then I will need to refer you elsewhere.

Family Contacts: Name: _____ Phone: _____ / Name: _____ Phone: _____

When a family is confronted by parental separation or divorce, it is very hard on everyone. It is particularly hard on children. When the parental relationship is unsafe, it is even more important that therapy presents a safe environment. That safety is particularly endangered where a child has to worry that what he or she says in therapy will be revealed in court and used against one of his or her parents. In order to protect that safety, I want us to all agree that either parent will not call the therapist as a witness in a legal hearing. Everyone needs to understand that a judge may decide not to honor this agreement and that I may be required to be a witness, although I will do my best to prevent that from happening.

You should be aware that once we start treatment, it is unethical of me to give any opinion about custody or visitation arrangement, even if I am compelled to be a witness. I want your permission to provide information to anyone who the court appoints to perform a custody evaluation or to represent the legal interests of your children. I will not make any recommendation about the final decision. It is my policy where there is joint legal custody to contact and visit with both parents and receive the consent of both parents unless there are very good reasons not to. With joint custody, either parent can demand an end to the therapy of his/her minor child. If a parent claims sole or joint legal custody, then the psychologist retains the right to request a copy of the divorce decree.

Initial: _____

Client Rights: (1) To not receive therapy from me and to be provides with names of other qualified professionals; (2) To ask any questions about the procedures used during therapy; (3) To end therapy at any time without any further moral, legal or financial obligation; (4) To review your records unless I feel this would cause possible damage to you or others; (5) Confer periodically about your progress and goals; and (6) Confidentiality.

Confidentiality: All information disclosed within a session is confidential and may not be revealed to anyone without the client’s written permission, except where disclosure is required by law and the above exceptions. Disclosure may be required where there is “reasonable suspicion” of the following: (1) child or elder abuse; (2) the client presents a danger of violence to others; or (3) the client is “gravely disabled” or is likely to harm him/herself unless protective measures are taken. Disclosure may also be required pursuant to certain legal procedures and if the client discusses the planning of a criminal action. Therapy needs to be a safe place for all participants and that parents need to know information about their children that allows them to fulfill their responsibilities as parents. The therapist will keep all information learned from and about a child confidential unless the child agrees that it will be shared. Therapist will encourage and assist the child or children in sharing information with parents where appropriate. Parents can receive regular reports from the therapist about how therapy is going. If the therapist judges a child to be at serious risk of harm or at serious risk of harming another person, he/she may non-consensually breach the child’s confidentiality.

Cancellations: A minimum 48 hours is required to cancel an appointment without charge.

Payment: I / we agree to pay on a per session basis the fee of \$ _____ per 50 minute clinical hour. Payment by cash, check or major credit card is agreed upon at the start of each session (unless the client prefers to do this at the completion of the session). Checks are payable to “Will Joel Friedman, Ph.D.”

Insurance: Upon request I will provide a monthly statement in the form of a receipt or super-bill with two copies for you to submit one copy to your insurance carrier for reimbursement directly to you and retain one copy for your records. Couple marital therapy ethically must be billed as a V-code (i.e., 90847).

I (we) have read, understand and agree to engage in therapy with Dr. Friedman under the above terms:

Print client(s) name (parent/guardian if minor)	Client Signature	Date
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Print client(s) name (parent/guardian if minor)	Client Signature	Date
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