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Counseling
by Penny Haight, M.Ed., LPC-S

# INFORMED CONSENT – MINOR

## TRAINING AND BACKGROUND

Karen Peninger, M.Ed., LPC-Intern is a Licensed Professional Counselor-Intern licensed by the Texas State Board of Examiners of Professional Counselors under the supervision of Penny Haight, LPC-S

I have worked with individuals of all ages, ethnicity, gender, religion, sexual orientation, and socio-economic status. Karen Peninger, M.Ed., LPC-Intern under the supervision of Penny Haight, LPC-S is trained in multiple methodologies including Applied Behavior Analysis (ABA), Solution Focused Brief Therapy (SFBT), Cognitive Behavioral Therapy (CBT), Play Therapy, Art Therapy, and Sand Tray Therapy. I am also a Certified School Counselor and Certified Positive Discipline Parent Educator.

## SESSION GUIDELINES

Sessions are 50 – 55 minutes. Sessions begin on the hour and end at the scheduled time. Late arrival on your part will not extend the scheduled ending time for a session. The frequency of sessions and the length of the psychotherapy are aspects of the work that you and I will decide together. Brief therapy is usually around 10 sessions. Some clients need additional sessions to reach their treatment goals. If there is a set time and day that works best for you and your child's schedule (e.g., every Monday at 5 PM) a recurring appointment may be arranged if that time and day is available. However, after 2 cancellations that recurring spot will be forfeited.

As a parent you have an input in the counseling relationship and may choose at any time to end the therapeutic relationship, **but please be aware that at all times the client is your child – not the parents/guardians nor any siblings or other family members of the child**. If at any time you are dissatisfied with my services as a therapist, you have a right to let me know. If you do not feel that I will resolve your complaint, you may file a formal complaint through contact with the Texas Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

You are responsible for any appointments that are not canceled at least 24 hours prior to the appointment time with the EXCEPTION OF AN EMERGENCY. **If you need to cancel an appointment a 24 hours' notice must be given otherwise a fee will be charged of $150 for the missed appointment.**

_____ Parent Initials

## PARENT AUTHORIZATION FOR A 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 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 policy to notify the other parent that the therapist is meeting with your child. It is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental
health evaluation or 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, the therapist will strive to listen carefully so that they can understand your perspectives and fully explain their 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, that Karen Peninger, M.Ed., LPC-I will honor that decision, unless there are extraordinary circumstances. However, in most cases, it is best to have a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with Me

In the course of treatment of your child, I may meet with the child's parents/guardians either separately or together. If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting for 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 of Treatment Information

In some situations, I am required by law or by the guidelines of the profession to disclose information, whether or not she has the parent's or your child's permission.

Confidentiality cannot be maintained when:

- Child clients disclose they plan to cause serious harm or death to themselves, and there is belief they have the intent and ability to carry out this threat in the very near future. Steps must be taken to inform a parent/guardian or others of what the child has disclosed and how serious this threat to is and to try to prevent the occurrence of such harm.
- Child clients disclose they plan to cause serious harm or death to someone else, and there is belief they have the intent and ability to carry out this threat in the very near future. In this situation, steps to inform a parent/guardian or others must be taken, including informing the person who is the target of the threatened harm [and 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, clinical judgment will be used to decide whether a parent/guardian should be informed.
- Child clients disclose, directly or indirectly, 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.
- When 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 therapist and the patient. 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.

**Intake**

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 clinical 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.

> ***For Example****:* If your child tells me that they have tried alcohol at a few parties, I would keep this information confidential. If your child tells me that they are drinking and driving or is a passenger in a car with a driver who is drunk, I would tell you. If your child tells me, or if I believe based on things I learn about your child, that they are addicted to drugs or alcohol, I would tell you.

You can always ask 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 you have agreed to keep your child's treatment information confidential if I believe that it is important for you to know about a particular situation that is going on in your child's life 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.

<u>Disclosure of Minor's Treatment Records to Parents</u>

Although the laws of Texas may give parents the right to see any written records kept about your child's treatment, by signing this agreement, you are agreeing that your child should have a "zone of privacy" in their therapy sessions. The Texas State Board of Examiners for Licensed Professional Counselors requires to notify you who would maintain my records in the case of my death or disability. Loretta Smith is the named custodian of my records and she has agreed to follow the guidelines set forth by the above-mentioned board. Additionally, you may sign a release form granting me permission to designated third parties to receive and send information that you request. I will never disclose your child's information for any reason without your knowing of her intent.

<u>Minor's Therapy Information/Records in Custody Litigation</u>

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. My responsibility is to your child but may require me helping to address any conflicts between the parents, my role will be strictly limited to providing treatment to your child.

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 report determinations as to what is in the best interest of the child's mental health. 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 at the rate of $2,500 per day for time spent speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.**

**Parent/Guardian of Minor Patient:**

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 general progress, and/or

may be asked to participate in therapy sessions as needed. _____ Parent Initials

- 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 UNLESS required by court. _____ Parent Initials

- 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. _____ Parent Initials

**FEES**

The fee is $150.00 per 50-55-minute session. Payment in full is due at the time services are rendered. Fees must be paid at the beginning of each session. When payments are collected at the end of a session, the momentum of the session can be de-railed.

Should I need to attend parent/teacher conferences, attend ARD meetings, conducting classroom observations, communicate with lawyers, communicate with insurance companies, complete documentation for medical needs, complete documentation for psychological evaluations, complete FMLA forms, complete ESA documentation, etc. **I charges a fee is $80 per half-hour.** Should you request for me to complete any documentation or attend any meetings without 48 hours' notice an additional expedited fee of $40 will be assessed. Should you subpoena me as a factual case witness or involve her in any court-related processes, **I charges a fee of $2,500.00 for legal depositions, case preparation, travel, and witness time.**

_____ Parent Initials

**CONTACT INFORMATION**

You may leave a message for me on a private, confidential voice mail (817-657-1115) at any time. Messages are checked daily, and she will return your call as soon as possible. However, this number is not an emergency phone number. **I does not provide 24-hour crisis counseling. Should your child experience an emergency necessitating immediate mental health attention call 9-1-1 or go to an emergency room for assistance.**

Contacting You

- Counseling by Penny Staff may leave appointment reminders or contact me via texting/calling this phone number _____ _____ _____ _____
- Counseling by Penny Staff may leave appointment reminders via email _____ _____ _____
- Counseling by Penny Staff can call this emergency contact in the event I can not be reached _____ _____

**Intake**

I have read the information contained in this Informed Consent. I consent to treatment for my child as described in this form. I have read a copy of the Confidentiality/HIPAA Practices. I understand this agreement.

Parent/Guardian Signature _____
Date_____

**INSURANCE**

Insurance card with this form to be photocopied

Name of Insured: _____ SSN: _____
Insured's DOB: _____ Insurance Carrier: _____
Benefit/Eligibility Phone Number: (_____) _____ - _____
ID#: _____ Group#: _____
Deductible: _____

Person responsible for bill: _____
Address: _____ CITY: _____ ST: _____
ZIP: _____

Insured's Employer: _____
Address: _____ CITY: _____ ST: _____
ZIP: _____

I authorize the release of any medical or other information necessary to process this claim.
_____ Parent Initials

I authorize payment of medical benefits to the provider of services. I understand that I am responsible for my bill, not my insurance company. I am aware that if my insurance company declines payment, I am responsible for my bill.
Parent/Guardian Signature _____
Date_____

Please describe your reason(s) for seeking treatment for you child at this time (Include when the problem started):
_____
_____
_____
_____

_____
_____

How would you know your child is doing better than before you started counseling?

_____
_____
_____
_____
_____
_____

Please list other health care professionals your child currently sees:

_____
_____
_____
_____

Please list any other health problems your child may have:

_____
____
_____
_____

Please list any current medications and dosage:

_____
_____
_____
_____

Has your child ever received counseling before? If yes, please indicate when, for how long, with whom,
and reason(s) for treatment:

_____
_____
_____
_____

Please list any relevant family history (family members, mental health diagnosis, abuse, divorce, etc.) or
additional information related to your child's mental health:

_____
_____
_____
_____
_____
_____

Please indicate past or current struggles:

___Depression ___Family Conflict ___Anger
___Chronic Illness ___Grief/Loss ___Domestic Violence
___Relationship Issues ___Eating or Weight Problem ___Phobias/Fears
___Anxiety ___Behavioral Problems
___Obsessions/Compulsions

**Intake**

| | | |
|---|---|---|
| ___Chronic Pain | ___ADHD | ___Manic Episodes |
| ___Sexuality/Sexual Issues | ___Abuse/Victimization | ___Trauma |
| ___Stress | ___Schizophrenia/Psychosis | ___Legal Matters |
| ___Loneliness/Isolation | ___Drug/Alcohol | ___Suicidal Thoughts |

Other:

_____ _____ _____
___ (Please explain)

**Intake**

# DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

**Child's Name:** _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

**Relationship with the child:** _____

**Instructions** *(to the parent or guardian of child):* **The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the past TWO (2) WEEKS.**

| | | During the past **TWO (2) WEEKS**, how much (or how often) has your child... | **None** Not at all | **Slight** Rare, less than a day or two | **Mild** Several days | **Moderate** More than half the days | **Severe** Nearly every day | **Highest Domain Score** (clinician) |
|---|---|---|---|---|---|---|---|---|
| I. | 1. | Complained of stomachaches, headaches, or other aches and pains? | 0 | 1 | 2 | 3 | 4 | |
| | 2. | Said he/she was worried about his/her health or about getting sick? | 0 | 1 | 2 | 3 | 4 | |
| II. | 3. | Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early? | 0 | 1 | 2 | 3 | 4 | |
| III. | 4. | Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game? | 0 | 1 | 2 | 3 | 4 | |
| IV. | 5. | Had less fun doing things than he/she used to? | 0 | 1 | 2 | 3 | 4 | |
| | 6. | Seemed sad or depressed for several hours? | 0 | 1 | 2 | 3 | 4 | |
| V. & VI. | 7. | Seemed more irritated or easily annoyed than usual? | 0 | 1 | 2 | 3 | 4 | |
| | 8. | Seemed angry or lost his/her temper? | 0 | 1 | 2 | 3 | 4 | |
| VII. | 9. | Started lots more projects than usual or did more risky things than usual? | 0 | 1 | 2 | 3 | 4 | |
| | 10. | Slept less than usual for him/her, but still had lots of energy? | 0 | 1 | 2 | 3 | 4 | |
| VIII. | 11. | Said he/she felt nervous, anxious, or scared? | 0 | 1 | 2 | 3 | 4 | |
| | 12. | Not been able to stop worrying? | 0 | 1 | 2 | 3 | 4 | |
| | 13. | Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous? | 0 | 1 | 2 | 3 | 4 | |
| IX. | 14. | Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her? | 0 | 1 | 2 | 3 | 4 | |
| | 15. | Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see? | 0 | 1 | 2 | 3 | 4 | |
| X. | 16. | Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else? | 0 | 1 | 2 | 3 | 4 | |
| | 17. | Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off? | 0 | 1 | 2 | 3 | 4 | |
| | 18. | Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned? | 0 | 1 | 2 | 3 | 4 | |
| | 19. | Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening? | 0 | 1 | 2 | 3 | 4 | |
| | | In the past **TWO (2) WEEKS**, has your child ... | | | | | | |
| XI. | 20. | Had an alcoholic beverage (beer, wine, liquor, etc.)? | ☐ Yes | ☐ No | ☐ Don't Know | | | |
| | 21. | Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco? | ☐ Yes | ☐ No | ☐ Don't Know | | | |
| | 22. | Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)? | ☐ Yes | ☐ No | ☐ Don't Know | | | |
| | 23. | Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)? | ☐ Yes | ☐ No | ☐ Don't Know | | | |
| XII. | 24. | In the past **TWO (2) WEEKS**, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide? | ☐ Yes | ☐ No | ☐ Don't Know | | | |
| | 25. | Has he/she EVER tried to kill himself/herself? | ☐ Yes | ☐ No | ☐ Don't Know | | | |

**Intake**

## CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Child

**To be completed by Parent/Caregiver**

*Today's Date:* _____

*Child's Name:* _____ *Date of birth:* _____

*Your Name:* _____ *Relationship to Child:* _____

***Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance.*** *Please read the statements below. Count the number of statements that apply to your child and write the total number in the box provided.*

***Please DO NOT mark or indicate which specific statements apply to your child.***

***1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box.*** ☐

**Section 1.** *At any point since your child was born...*

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

***2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box.*** ☐

**Section 2.** *At any point since your child was born...*

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion