DONIELLE I. TURNER
Behavior Specialist

Email address: _____

CHILD INTAKE FORM

Today's date: _____/_____/_____

(*Please print and complete all items on this form)

CLIENT INFORMATION

Name of person filling out this form: _____

Child's Name: _____ Date of Birth: ___/___/___

Address: _____
City Zip

Home Phone: (___)_____ Work: (___)_____ Cell: (___)_____

Social Security Number: _____ Age: _____ Gender: ☐ Male ☐ Female

Race (optional): ☐ African American ☐ Asian ☐ Hispanic ☐ White ☐ _____ (Specify)

Parents are currently: ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ _____ (Specify)

Child's legal guardian is: _____

Mother's Name: _____

Address: _____
City Zip

Home Phone: _____ Work: _____ Cell: _____

Father's Name: _____

Address: _____
City Zip

Home Phone: _____ Work: _____ Cell: _____

Stepparent's Name(s):

_____

Address: _____
City Zip

Home Phone: _____ Work: _____ Cell: _____

Please list the names and ages of any siblings including step and half siblings: _____

_____

Name of current school attending and grade level:

_____

Please list any current extracurricular activities your child is involved in:

_____

CLIENT HISTORY

1. Has your child ever received counseling, psychological, alcohol or drug treatment before?

☐ Yes ☐ No If yes, please indicate:

From Whom? For what? When? With what results?

2. Has your child ever been prescribed medications for psychiatric or emotional problems?

☐ Yes ☐ No If yes, please indicate:

From Whom? For what? Name of Medication(s) With what results?

3. Please list any inpatient psychiatric hospitalization/s: (include dates of treatment)

4. Please list name of your child's primary care physician: _____

Phone Number Address City Zip

May I, Donielle I. Turner, contact your child's primary care physician to coordinate his/her care?

☐ Yes ☐ No

5. Please list any current medical illnesses, or health-related concerns: _____

6. Please list any current medications: (include name of doctor prescribing medication and any over the counter medications or herbal remedies) _____

7. Please list any hospitalizations or surgeries: (include approximate dates) _____

8. Does your child have any current legal charges, court involvement or under court order to receive services (circle one)? Yes No If yes, please explain: _____

9. Please list any family history of mental illness or chemical dependency: _____

10. What are your goals for counseling? _____

SYMPTOMS LIST

PLEASE CHECK ALL THAT APPLY:

***Parents, if possible, please allow your child to complete this form. If your child is too young, complete symptom check list from your observations of your child.**

	Headaches		Memory problems		Depression
	Sleep problems		Heart palpitations		Feeling tense or nervous
	Academic concerns		Ideas of harming yourself		Drug use
	Worries about money		Feeling shy around others		Not confident
	Having a lack of friends		Stomach problems		Concerned about eating habits
	Feelings of panic, fear, phobias		Trouble concentrating		Alcohol use
	Feeling sad or depressed		Grief or loss		Nightmares
	Feeling restless		Feelings of hopelessness		Feelings of worthlessness
	Low self-esteem		Disturbing thoughts		Hallucinations
	Aggression		Mood swings		Recurring thoughts
	Chest pain		Suicidal thoughts		Trembling
	Sexual concerns		Sexual identity concerns		Anger
	Ideas of harming others		Memory problems		Chronic pain
	Blaming or criticizing self		Abusing others		Dizziness
	Feeling tired		Feeling a need to be on the go		Problems at home
	Anxiety		Antisocial or illegal behavior		Concerned about family members
	Irritability		Abused by others		Sick often
	Isolating self		Disorganized thoughts		Relationship problems
	Distractibility		Impulsive		Poor judgment

Please add any other information about your child that would be helpful for the counselor to know.

_____

_____

_____

_____

REFERRAL INFORMATION

How did you hear about Donielle I. Turner, Behavior Specialist? _____

_____

_____

_____

_____

_____

_____

_____

_____

FINANCIAL AGREEMENT

This form should be completed by the person responsible for payment.

Last Name:_____ First Name: _____Middle Initial:_____

Social Security Number:_____ Date of Birth:_____

Address:_____ City:_____ State:_____Zip: _____

Cell Phone: _____

Do you consent to receive phone calls or text messages regarding bill and payment (circle one)? Yes No

Name of Employer:_____

Employer Address:_____City:_____State: _____Zip:_____

Employer Phone Number: _____ Position/Title: _____

____ *I understand that I am responsible for full payment of my bill.* Additionally, I agree to pay at the time of service all fees due, including any charges for returned checks.

____ I understand that if a session is missed without canceling or cancel with less than 24 (twenty-four) hours' notice, for non-emergency reasons, I will be charged $100.00.

____I understand fees for the initial visit are $100.00 and fees for each subsequent session are $100.00

I have read the above, understand, and accept the policies described herein. I certify that the above information is complete and accurate and understand all information is subject to verification by Donielle I. Turner, Behavior Specialist.

_____ _____

Signature of Person responsible for bill Date

AGREEMENT FOR PARENTS OF MINOR CHILDREN

Psychotherapy can be a very important resource for children. Establishing a therapeutic alliance can:

- Facilitate open and appropriate expression of strong feelings such as guilt, grief, sadness and anger.
- Provide an emotionally neutral setting in which children can explore these feelings.
- Help children understand, accept, and cope with whatever difficulty they may be experiencing.
- Offer feedback and recommendations to a child's caregivers based on knowledge of the child's specific emotional needs and developmental capacities.

However, the usefulness of therapy may be limited when the therapy itself simply becomes another matter of dispute between parent and child or between parents. With this in mind, and in order to best help your child, I strongly recommend that your child and each of the child's caregivers (e.g., parents or stepparents) mutually accept the following as requisites to participation in therapy.

1. As your child's psychotherapist, it is my primary responsibility to respond to your child's emotional needs. This includes, but is not limited to, contact with your child and each of his or her caregivers, and gathering information relevant to understanding your child's welfare and circumstances as perceived by important others (e.g., pediatrician, teachers). In some cases, this may include a recommendation that you consult with a physician, should matters of your child's physical healthbe relevant to this therapy.

2. I ask that all caregivers remain in frequent communication regarding this child's welfare and emotional well-being. Open communication about his or her emotional state and behavior is critical. In this regard, I invite each of you to initiate frequent and open exchange with me as your child's therapist.

3. I ask that caregivers recognize and, as necessary, reaffirm to the child, that I am the child's helper. This may include encouragement for the child that is reluctant or anxious about therapy, or support and optimism regarding change. Also, I have found that use of therapy as a consequence or punishment is usually not helpful.

4. This psychotherapy will not yield recommendations about custody. In general, I recommend that parties who are disputing custody strongly consider participation in alternative forms of negotiation and conflict resolution, including mediation and custody evaluation, rather than try to settle a custody dispute in court.

5. Please be advised regarding the limits of confidentiality as it applies to psychotherapy with a child:

    a. When I treat children under the age of about 12, I must tell their parents or guardians whatever they ask me. As children grow more able to understand and choose, they assume legal rights.

    b. In cases where I treat several members of a family (parents and children or other relatives), the confidentiality situation can become very complicated. I may have different duties toward different family members. At the start of our treatment, we must all have a clear understanding of our purposes and any limits on confidentiality that may exist and my role.

    c. In the case of separation or divorce, any matter brought to my attention by either parent regarding the child may be revealed to the other parent. Matters which are brought to my attention that are irrelevant to the child's welfare may be kept in confidence. However, these matters may best be brought to the attention of others, such as attorneys, personal therapists or counselors.

    d. **I am legally obligated to bring any concern regarding the child's health and safety to the attention of relevant authorities. When possible, should this necessity arise, I will advise all parties regarding my concerns.**

Your signature, below, signifies that you have read and accept these points.

_____ _____

Signature of Parent or Legal Guardian Date

PROFESSIONAL DISCLOSURE STATEMENT
AND INFORMED CONSENT

Psychotherapy requires your very active involvement. It will be important for you to be honest with me about your feelings, emotions, and experiences. Therapy is most effective when you feel trust in our therapeutic partnership and are open to change and the uncomfortable feelings that may be associated with stepping outside your typical way of viewing life, yourself and others.

We will plan our work together. I expect us to agree on a plan that we will both work hard to follow. In our treatment plan, we will list the areas to work on, our goals and the methods we will use. From time to time, we will look together at our progress and goals and if we think we need to, we can make changes.

Many different techniques will be utilized in order to work towards increasing your self-awareness and personal growth. Techniques may include dialogue, education, relaxation strategies, reframing negative thoughts, art and writing exercises, or role-playing positive communication techniques. An important part of your therapy will be practicing the new skills you learn. I will ask you to practice outside our sessions and we will work together to set up homework assignments for you. You can expect the unfamiliar feelings often associated with change to dissipate as you begin to incorporate the various techniques into your life.

Change will sometimes be easy and quick, or it may be slow and frustrating. There are no instant cures and no "magic pills." However, you can learn new ways of looking at your problems that will be very helpful in developing more positive ways of coping with your current situation.

I may refer you to other professionals, such as doctors, nutritionists, or other supportive services if I feel that you would benefit from additional resources. I believe in a collaborative approach and would request you to fill out a release of information form, so that I may talk with these other professionals. You may, as with all aspects of your treatment, decline such recommendations.

The process of ending therapy, "termination," can be a very valuable part of our work. Stopping therapy should not be done casually. If you wish to terminate therapy, I ask that you schedule an "Agree to Terminate" session where we will review our goals, the work we have done, and any future work that needs to be done.

The following are two exceptions to our joint decision to end therapy:

(1) If I am, in my judgment, not able to help you, because of the nature of your presenting concerns/diagnosis/medical illness or because my training and skills are, in my judgment, not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs.

(2) Verbal or physical threats, harassment, and violence towards me, my family, or my co-workers may result in an immediate and unilateral termination of treatment. If I terminate you from therapy, I will offer you referrals to other sources of care but cannot guarantee that they will accept you for therapy.

Your signature, below, signifies that you (and/or your child) have read and accept these points:

_____ _____

Signature of Parent or Lega Guardian Date

The Benefits and Risks of Therapy

As with any treatment, **psychotherapy involves some potential risks**. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings. In addition, a client's problems may temporarily worsen during the beginning of treatment. Most of these risks are to be expected when people are making important changes in their lives. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful.

Confidentiality

In all but a few rare situations, you have the absolute right to the confidentiality (that is, the privacy) of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. Under the provisions of the Health Care Information Act of 1992, I will always act so as to protect your privacy even if you do release me in writing to share information about you. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. You will be given a copy of my Notice of Privacy Practices and you will be asked to sign a client consent for the use and disclosure of protected health information.

In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional or a family member some information to protect your life.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect. In any of these situations, I would reveal only the information that is needed to protect you or the other person.

a) If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services.

b) If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police. I am not obligated to do this and would explore all other options with you before I took this step. However, if at that point you were unwilling to take steps to guarantee your safety, I would call the police.

c) If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

d) If your records are subpoenaed by court order, I may be required to disclose confidential information.

Children and families create some special confidentiality questions.

a. Confidentiality also extends to parents. Other than the exceptions listed above, I will not share with the specifics of what your child said or did during a session unless your child gives me permission to do so. I will, however, talk with you on a regular basis about your child's therapeutic progress, treatment goals, your expectations for therapy, and your concerns and hopes for your child.

b. I also request that you respect the right of confidentiality of others that you may see at this practice. I ask my clients to not disclose the identity of those they may see coming or going, as each individual has the right to decide with whom they share this information.

My Role in Our Therapeutic Partnership

I can only be your therapist. I cannot have any other role in your life. I cannot, now or ever, be a close friend or socialize with any of my clients. I cannot be a therapist to someone who is already a friend. I can never have a sexual or romantic relationship with any client during, or after, the course of therapy. I cannot have a business relationship with any of my clients other than the therapy relationship.

About Our Appointment

The frequency of our sessions will be a joint decision. An appointment is a commitment to our work. If you are late, we will be unable to meet for the full time.

If you miss a session without canceling or cancel with less than 24 (twenty-four) hours' notice, for non-emergency reasons, you will be charged $100.00.

Fees and Payment

I agree to provide psychotherapy services in return for a fee of $100 for an initial intake session and $100 per each subsequent session. Payment or co-payment for each session will be collected at the start of each session. Cash, personal checks, or mobile payment applications (Apple Pay, Cash App, PayPal, Zelle) are accepted.

If there is any problem with my charges, my billing, or any other money-related point, please bring it to my attention. Such problems can interfere greatly with our work. If you think you may have trouble paying your bills on time, please discuss this with me. I am not willing to have clients run a bill with me and any overdue payments will be charged 1.5% per month interest. There will be a $35 charge for all returned or bounced checks. Please be aware that following the second returned or bounced check, you will be required to pay all fees in cash. If you eventually refuse to pay your debt, I reserve the right to give your name and the amount due to a collection agency and must end therapy at that time.

Consultation

During the course of treatment, consultation may be a required and/or necessary part of your care. Payment for such will berequired on the date of service. Time spent in phone consultation or attendance at school conferences, such as IEP meetings, will be billed at $50.00 an hour. Any requested administrative work, beyond what it is provided at the end of each session, will be charged an administrative fee of $25.00 for 1-20 minutes. Each additional 20-minute increment will be billed at $25.00.

Client Consent to Psychotherapy

I acknowledge that I, the client (or his or her parent or guardian), have received, have read (or have had read to me), and understand the "Informed Consent". I have discussed those points I did not understand, and have had my questions, if any, fully answered. I understand that after therapy begins, I have the right to withdraw my consent to therapy at any time, for any reason. Furthermore, I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

I, or as the legal guardian of_____, do hereby seek and consent to take part in psychotherapy servicesprovided by Donielle I. Turner, Behavior Specialist. I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessaryfor therapy to be effective.

My signature below shows that I understand and agree with all of the statements contained in this document.

_____ _____

Signature of Parent or Legal Guardian Date

CLIENT RIGHTS AND RESPONSIBILITIES

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to knowabout. There are also certain limitations to those rights.

Your rights as a Therapy Client:

- Receive respectful treatment that will be helpful to you.
- Receive treatment in a safe setting, free from sexual, physical, and emotional abuse.
- Ask for and get information about my qualifications, including my license, education, training, experience, membership in professional groups, special areas of practice, and limits on practice.
- Have written information, before entering therapy, about fees, confidentially, method of payment, insurance coverage, and cancellation policies.
- Share with me aspects of our sessions that you believe are helpful for you and which aspects are not.
- Refuse to answer any question or give any information you choose not to answer or give.
- Ask that I inform you of your progress.
- File a complaint with the government or my professional association if you believe that you have been treated unethically.
- Refuse any treatment offered or suggested.
- End therapy at any time. The only thing you will have to do is to pay for any sessions you have already received.
- Ask any questions, at any time, about what we do during therapy, and have any therapy procedureor method explained before it is used.
- You have the right to keep what you tell me private. Generally, no one will learn of our work without your written permission. There are some situations in which I am required by law to revealsome of the things you tell me, even without your permission.

These exceptions are:

a) If you seriously threaten to harm another person, I must warn that person and the authorities.

b) If a court orders me to testify about you, I must do so.

c) If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services or Adult Protective Services.

d) If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police. I am not obligated to do this and would explore all other options with you before I took this step. However, if at that point you were unwilling to take steps to guarantee your safety, I would call the police.

Your Responsibilities as a Therapy Client

- You are responsible for actively participating in our therapeutic partnership, by making a commitment to your success, which includes addressing feelings which may be difficult or uncomfortable, following through with homework, honestly sharing your thoughts and feelings, actively participating in the development of your goals, making sure your goals are understood, and being on time for your sessions.

- You are responsible for canceling your session with at least twenty-four hours' notice, unless it is deemed an emergency, otherwise you will be charged $100.

- You, not your insurance company or any other person or company, are responsible for paying the fees we agree upon.

- You are responsible for knowing how to contact me or other resources in case of an emergency.

My signature below acknowledges that I, the client or his/her parent or guardian, have received, have read (or have had read to me), and understand the "Client Rights and Responsibilities" form. I have discussed those points I did not understand, and have had my questions, if any, fully answered.

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Signature of Therapist Date

Donielle I. Turner, Behavior Specialist
info@donielleturner.com
www.donielleturner.com

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

▶ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

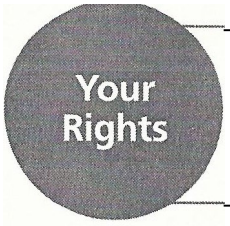
▶ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

▶ ***See pages 3 and 4*** *for more information on these uses and disclosures*



When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

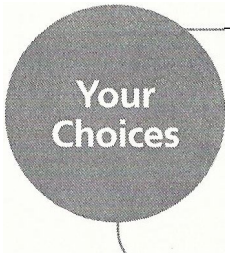
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.



For certain **health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, I *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: *A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: *We use health information about you to manage your treatment and services.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following practice:
Donielle I. Turner, Behavior Specialist

I understand that one of my rights is to be able to choose how I am *contacted.*

I do/do not (please circle one) give permission to be contacted at work.
I do/do not (please circle one) give permission for you to leave a voice mail message for me at home/work/neither (please circle).
Furthermore, I understand that if I choose to communicate with my therapist via email or text messaging regarding appointment requests or changes, that email and text may not be confidential.

_____ _____
Signature of Parent or Legal Guardian *Date*