Janet Bastien LMFT
Carlsbad Family Counseling, Inc.
2945 Harding St. Ste. 205 Carlsbad CA 92008 | 858-240-9105 | carlsbadfamilycounseling@gmail.com

TREATMENT AGREEMENT FOR CHILDREN

FEES: The fee per 50-minute session is $_____ (except for the first session, which is $_____). This is payable at the time of our session, unless I am billing your insurance (see below for insurance billing information).

CANCELLATION: Sessions are by appointment only, Monday through Thursday. While I hate charging for missed sessions, I do reserve that time for you. Therefore, you will be charged $_____ (not just a copayment) for missed sessions or for those cancelled without 24-hour notice, except in medical emergency. Insurance will not pay for missed sessions. Since your time is also valuable, if I forget a session, you get one session free.

INSURANCE: It is essential that you tell me about all possible insurance plans you have that might cover my services (ex. if a child might have coverage through both parents' plans). Please be aware that I will be required to provide a diagnosis on invoices and claims, and coverage may be limited to certain mental conditions. Even if you have coverage for unlimited sessions, health plans may review treatment, limit coverage, and request treatment notes. While I may check coverage for you, you are responsible for verifying and understanding the limits of your coverage. Although I am happy to assist you in obtaining reimbursement, I am unable to guarantee whether your health plan will provide payment for the services provided.

If I am a provider with your plan: I will submit claims for you, but at our session you must pay copayments and any portion not covered by your plan. There may be a deductible (an annual amount you will need to pay out of pocket before your plan begins to cover sessions). If insurance does not pay as expected, you remain responsible for the balance.

If I am NOT a provider for your plan: You will pay me in full at the session. I can give you an invoice if you wish to seek reimbursement from your plan, though many plans do not cover sessions with a provider who is not in their network.

PLEASE SIGN THE FOLLOWING, IF USING YOUR INSURANCE PLAN OR EMPLOYEE ASSISTANCE PROGRAM:

1. *"I authorize the release of any information (Including notes, treatment summaries and diagnosis) necessary to process insurance claims, to determine medical necessity of treatment, to request additional sessions, or to comply with mandated quality control function or administrative chart reviews from the insurance plan."*

(Parent or Guardian: Sign here): X _____

(If applicable, Second Parent signature): _____

2. *"I authorize payment of benefits to be made to Janet K. Bastien, LMFT for services provided."*

(Parent or Guardian: Sign here): X _____

CONFIDENTIALITY: Client attendance, information, and records are protected and confidential. Since openness and trust are essential to effective therapy, it is important that a teen or child feels s/he has privacy to discuss all the issues that are troubling them. While parents have a right to know about their child's progress in therapy, I will limit disclosures to parents to what I feel is in the child's best interest, what the child has given me permission to share, or when there are safety issues. Since the goal is to build trust and minimize secrets, clients will be made aware of any communications with family members. I will make disclosures or reports as required or allowed by law (ex. suspected child abuse or neglect, extreme danger to self, suspected elder abuse, or danger to others), and other instances outlined in my Notice of Privacy Practices.

IN AN EMERGENCY: Contact me via text, e-mail and voicemail. You may also go to the emergency room, dial 911 or Crisis Hotline number 888-724-7240.

ENDINGS: If you or your child is unhappy with any aspect of therapy, please don't just leave – I ask that you talk to me to see if we can work it out. Even if we can't, endings usually feel better this way. Of course, you may end therapy at any time, and I am happy to assist with referrals. It is my ethical duty to provide therapy only when I feel you are actively participating and benefiting from the sessions. I may end treatment if there have been repeated no-shows, late-cancellations or other treatment interruptions.

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TREATMENT AGREEMENT FOR CHILDREN (CONT'D)

E-MAIL/SOCIAL MEDIA: In general, text, e-mail is the quickest way to reach me. I use text or e-mail to arrange/change appointments. I do not do therapy by e-mail. When cancelling, please leave BOTH a voicemail and e-mail. Please do not e-mail me information related to your therapy, as e-mail is not completely confidential, and important issues should be reserved for sessions. Be aware that e-mails between us become part of your legal record. I do not accept friend requests or contact requests from clients on social networking sites (Facebook, LinkedIn, etc.) out of concern for your confidentiality and my privacy. It may also blur the boundaries of our therapy relationship.

REFERRALS/GROUP: A referral to another provider may become necessary if it becomes clear in my opinion that your child's issues would be better treated by a professional with different expertise. It is unethical for me to practice beyond the level of my competence, education, training, or experience. I am not responsible for the care received from professionals to whom I refer you. Agreements made between you and I do not involve other profession-als in the office suite, who each operate independent solo practices, and are not part of a group.

CHILD CUSODY/COURT CASES: I do not participate in court cases... If at any time your case takes on a legal standing I will evaluate it, if it is in the clients best interest to be referred to another clinician that will be available or willing to address and communicate with your various legal counsels.

PATIENT RIGHTS: A list of your client rights is posted in the office. You have the right to ask any questions about your treatment or refuse to participate in treatment at any time. This office does not discriminate in the delivery of health care services based on race, ethnicity, national origin, citizenship or immigration status, religion, gender, age, mental or physical disability, medical condition, sexual orientation, medical history, evidence of insurability, or source of payment.

By signing below, you acknowledge you have read this Agreement, and you acknowledge receipt of my *Notices of Privacy Practices*. My *Notice of Privacy Practices* provides information about how I may use and disclose your private health information. I encourage you to read it in full. My *Notice of Privacy Practices* is subject to change. If I change my Notice, I will give you a revised Notice. If you have left treatment, you may obtain the revised notice from me at the above address and phone number.

If you have any questions about the Notice, or any of the above, please feel free to ask.

X _____	**X** _____	**X** _____
Signature, Minor Client	Printed Name, Client	Date
X _____	**X** _____	**X** _____
Signature, Parent or Guardian	Printed Name, Parent or Guardian	Date
X _____	**X** _____	**X** _____
Signature, Second Parent, if applicable	Printed Name, Second Parent	Date