SIGIL
SOCIAL FOUNDATION
41715 Enterprise Circle N #102, Temecula, CA 92590
951-290-2997

AGREEMENT FOR SERVICE / INFORMED CONSENT FOR MINORS

Introduction
This Agreement has been created for the purpose of outlining the terms and conditions of services to be provided by the Sigil Social Foundation(herein "Therapist"), for the minor child(ren) _____(herein "Client") and is intended to provide [name of parent(s)/legal guardian(s)] _____ (herein "Representative(s)") with important information regarding the practices, polices and procedures of Therapist, and to clarify the terms of the professional therapeutic relationship between Therapist and Client. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Policy Regarding Consent for the Treatment of a Minor Child
Therapist generally requires the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of Representative to give consent for psychotherapy, Therapist will require that Representative submit supporting legal documentation, such as a custody order, prior to the commencement of services. Additional parental consent for Child Services are attached to this document.

Information About Your Child's Therapist
At an appropriate time, your therapist will discuss their professional background with you and provide you with information regarding their experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience, and professional orientation.

Your therapist is a:
☐ Licensed Psychologist
☐ Licensed Marriage and Family Therapist
☐ Licensed Clinical Social Worker
☐ Registered Psychologist*
☐ Psychological Assistant*
☐ Marriage and Family Therapist Registered Intern*
☐ Marriage and Family Therapist Trainee*
☐ Associate Clinical Social Worker*
* If your therapist is one of these selections, his or her practice is conducted under the supervision of a licensed mental health professional. The clinical Supervisor's name, license type and licensure are listed below:

_____	_____	_____
Name of Clinical Supervisor	License Type	License Number

Fees and Insurance
Our rates start at $125.00 per 45-minute session however our actual fee may be different

depending on individual agreement on a client-by-client basis.

The fee for service is $_____per individual therapy session.
The fee for service is $_____per conjoint (marital/family) therapy session.
The fee for service is $_____per group therapy session.

Individual Sessions and conjoint (marital/family) sessions are approximately 45 minutes in length. Clients are expected to pay for services at the time services are rendered. Therapist accepts cash, checks, and major credit cards. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure.

Please inform your therapist if you wish to utilize health insurance to pay for services. Although your therapist/provider is happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with your therapist.

If for some reason you find that you are unable to continue paying for your therapy, please inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

Risks and Benefits of Therapy
It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Due to the varying nature and severity of problems and the individuality of each client, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Professional Consultation
Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Client.

Records and Record Keeping
Therapist may take notes during session, and will also produce other notes and records regarding Client's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of the Sigil Social Foundation. Therapist will not alter his/her normal record keeping process at the request of any client. Should Client request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Client with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. The Sigil Social Foundation will maintain Client's records for 10 years or until the minor turns 21, whichever is longer, based on the rationale that 10 years is the time limit (statute of limitations) for complaints of sexual misconduct against the therapists to be filed with the Board of Behavioral Sciences.

Confidentiality
The information disclosed by Client is generally confidential and will not be released to any third party without written authorization from Client, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a client makes a serious threat of violence towards a reasonably identifiable victim, or when a client is dangerous to him/herself or the person or property of another. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others), in certain circumstances, to provide FBI agents with books, records, papers, documents, and other items and prohibits the therapist from disclosing to the client that the FBI sought or obtained the items under the Act.

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment.

Psychotherapist-Client Privilege
The information disclosed by Client, as well as any records created, is subject to the psychotherapist-client privilege. The psychotherapist-client privilege results from the special relationship between Therapist and Client in the eyes of the law. It is akin to the attorney-client privilege or the doctor-client privilege. Typically, the client is the holder of the psychotherapist-client privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-client privilege on Client's behalf until instructed, in writing, to do otherwise by Client or Client's representative. Client should be aware that he/she might be waiving the psychotherapist-client privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Client should address any concerns he/she might have regarding the psychotherapist-client privilege with his/her attorney.

Insurance
Client is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payor. Client is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles.

Therapist is a contracted provider with the following companies: [insert the names of companies with which Therapist is a contracted provider] _____, and has agreed to a specified fee. If Client intends to use benefits of his/her health insurance policy, Client agrees to inform Therapist in advance.

Client Litigation
Therapist will not voluntarily participate in any litigation, or custody dispute in which Client and another individual, or entity, are parties. Therapist has a policy of not communicating with Client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Client's legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Client, Client agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary hourly rate of $125 per hour.

Cancellation Policy
Client is responsible for payment of the agreed upon fee for any missed session(s). Client is also responsible for payment of the agreed upon fee for any session(s) for which Client failed to give Therapist at least 24 hours notice of cancellation. Cancellation notice should be left on Therapist's voice mail at _____.

Therapist Availability/Emergencies
Therapist's office is equipped with a confidential voice mail system that allows Client to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call.

If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail message.

In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis:

Crisis Hotline: 951-686-4357
Youth Shelter: Operation Safe House 800-561-6944 or 951-351-4418
Domestic Violence Help: Alternatives to DV (951) 683-0829; 1-800-339-SAFE (7233)
Hospital:

Rancho Springs Medical Center	2500 Medical Center Dr., Murrieta	951-969-6000
Inland Valley Medical Center	36485 Inland Valley Dr., Wildomar	951-677-9712
Riverside County Regional MC	4445 Magnolia Ave., Riverside	951-486-4000
Menifee Valley Medical Center	28400 McCall Blvd., Sun City	951-679-8888
Hemet Valley Medical Center	1117 E. Devonshire Ave., Hemet	951-652-2811

Therapist Communications

Your therapist may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

☐ My therapist may call me at my home. My home phone number is: ( ) _____ _
☐ My therapist may call me on my cell phone. My cell phone number is: ( ) _____
☐ My therapist may call me at work. My work phone number is: ( ) _____
☐ My therapist may send mail to me at my home address.
☐ My therapist may send mail to me at my work address.
☐ My therapist may communicate with me by email. My email address is: _____

Termination of Therapy
Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Client needs are outside of Therapist's scope of competence or practice, or Client is not making adequate progress in therapy. Client has the right to terminate therapy at his/her discretion. Upon either party's

decision to terminate therapy, Therapist will generally recommend that Client participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Client.

Acknowledgement

By signing below, Client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Client has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Client's satisfaction. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Client agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment. I also acknowledge that I have received the Notice of Privacy Practices from Sigil Social Foundation staff. The Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from the Sigil Social Foundation by calling the phone number listed on the first page of this document. I understand the limits of confidentiality, privacy policies, the children's rights, my rights, and their meanings and ramifications.

_____

Client Name (please print)

_____

Signature of Client (if Client is 12 or older) Date

_____

Signature of Representative (and relationship to Client) Date

_____

Signature of Representative (and relationship to Client) Date

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

_____

Name of Responsible Party (Please print)

_____

Signature of Responsible Party (and relationship to Client) Date

_____

Name of Responsible Party (Please print) Date

_____

Signature of Responsible Party (and relationship to Client) Date

SIGI SOCIAL FOUNDATION

Parental Consent for Child Services

The involvement of children and adolescents in therapy can be highly beneficial to their overall development. Very often, it is best to see them with parents and other family members; sometimes they are best seen alone. I will assess which might be best for your child and make recommendations to you. Obviously, the support of all the child's caregivers is essential, as well as their understanding of the basic procedures involved in counseling children.

The general goal of involving children in therapy is to foster their development at all levels. At times, it may seem that a specific behavior is needed, such as to get the child to obey or reveal certain information. Although those objectives may be part of overall development, they may not be the best goals for therapy. Again, I will evaluate and discuss these goals with you.

Because my role is that of the child's helper, I will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist.

The issue of confidentiality is critical in treating children. When children are seen with adults, what is discussed is known to those present and should be kept confidential except by mutual agreement. Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their parents have this right. However, unless children feel they have some privacy in speaking with a therapist, the benefits of therapy may be lost. Therefore, it is necessary to work out an arrangement in which children feel that their privacy is generally being respected, at the same time that parents have access to critical information. This agreement must have the understanding and approval of the parents or other responsible adults and of the child in therapy.

The following circumstances override the general policy that children are entitled to privacy while parents or guardians have a legal right to information.

- Confidentiality and privilege are limited in cases involving child abuse, neglect, molestation, or danger to self or others. In these cases, the therapist is required to make an official report to the appropriate agency and will attempt to involve parents as much as possible.

- Minors may independently enter into therapy and claim the privilege of confidentiality in cases involving abuse or severe neglect, molestation, pregnancy, or communicable diseases, and when they are on active military duty, married, or officially emancipated. They may seek therapy independently for substance abuse, danger to self or others, or a mental disorder, but parents must be involved unless doing so would harm the child, *(These circumstances may vary from state to state, and the specific laws of each state must be followed.)*

- Any evaluation, treatment, or reports ordered by or done for submission to a third party, such as a court or a school, is not entirely confidential and will be shared with that agency with your specific written permission. Please also note that I do not have control over information once it is released to a third party.

Now that the various aspects surrounding confidentiality have been stated, the specific agreement between you and your child/children follows:

I, (name) _____(relationship to child) _____

I, (name) _____(relationship to child) _____

agree that my/our child/children

(name) _____
(name) _____
(name) _____

should have privacy in his/her/their therapy sessions, and I agree to allow this privacy except in extreme situations, which I will discuss with the therapist. At the same time, except under unusual circumstances, I understand that I have a legal right to obtain this information. To increase the effectiveness of the therapy, I agree to the following:

I will do my best to ensure that therapy sessions are attended and will allow my child privacy inside their sessions so that they can get the therapy they need. If my child prefers/children prefer not to volunteer information about the sessions, I will respect his/her/their right not to disclose details. Basically, unless my child has/children have been abused or is/are a clear danger to self or others, the therapist will normally tell me only the following:

- whether sessions are attended
- whether my child is/children are generally participating or not
- whether progress is generally being made

The normal procedure for discussing issues that are in my child's/children's therapy will be joint sessions including my child/children, the therapist, and me and perhaps other appropriate adults. If I believe there are significant health or safety issues that I need to know about, I will contact the therapist and attempt to arrange a session with my child/children present. Similarly, when the therapist determines that there are significant issues that should be discussed with parents, every effort will be made to schedule a session involving the parents and the child/children. I understand that if information becomes known to the therapist and has a significant bearing on the child's/children's well-being, the therapist will work with the person providing the information to ensure that both parents are aware of it. In other words, the therapist will not divulge secrets except as mandated by law, but may encourage the individual who has the information to disclose it for therapy to continue effectively.

Parent/Guardian Signature _____ Date: _____/_____/_____

Parent/Guardian Signature _____ Date: _____/_____/_____

Minor's Signature _____ Date: _____/_____/_____

Minor's Signature _____ Date: _____/_____/_____

Therapist Signature _____ Date: _____/_____/_____