CDCW

COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD.

Child and Adolescent Services Contract

I/we, the undersigned, parent(s)/guardian(s) of _____, acknowledge that my/our son/daughter is the patient of Counseling and Diagnostic Center. Prior to beginning treatment, it is important for you to understand my approach to therapy with minors and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Patient-Therapist Agreement. Under HIPAA and the APA Ethics Code, I am legally and ethical responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If you decide that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship (assuming a longer than short-term therapy relationship is established).

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. However, this is not meant to, in any way, exclude you from, or leave you out of the process of your child's treatment. It helps promote progress by providing a secure, trusting environment in which your child can speak, as well as promoting you child's legal right to privacy.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. At the end of your child's treatment, I will meet with you to summarize what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and

opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

The Illinois Mental Health and Developmental Disabilities Confidentiality Act (MHDDCA) mandates a psychologist to "warn" any intended victim, as well as the responsible authorities, where a patient discloses in session that he or she intends to cause physical harm to a specifically identifiable victim. It is then the psychologist's responsibility to take steps to notify the victim and/or local authorities and provide enough information with which the authorities and/or the victim might prevent the harm from occurring. Therefore, if a patient discloses intent to harm a specific person, I must either contact that person and the authorities, or attempt to secure the hospitalization of the patient. These disclosures are also protected by an immunity clause in the statute.

Additionally, the Abused and Neglected Children's Reporting Act (ANCRA) in Illinois requires that "mandated reporters" must disclose any **suspected** instances of abuse or neglect of minors to the Illinois Department of Children and Family Services (DCFS). As a mental health practitioner, I am a mandated reporter. If the above is suspected, the law **absolutely requires** that a phone call be made to DCFS, such that DCFS may investigate the situation. The statute also provides the mandated reporter with absolute immunity from any criminal or civil liability in the event that such a report is made, **even without the consent of the patient.**

Although my responsibility to your child may require my involvement in conflicts between the two parents, I require your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that each of you will treat anything that is said in session with me as confidential. By signing below, you both also agree that neither of you will attempt to gain advantage in any domestic legal proceeding from my involvement with your child. In particular, I ask that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. I also prefer that you instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done. I am not a custody evaluator and, as your child's therapist, ethically cannot put myself in that role.

Please note that this agreement may not prevent a judge from requiring my testimony, and if I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. 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 not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $250 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Summary of Contract

- If you decide to terminate treatment, I have the option of having a few closing sessions with your child to properly end the treatment relationship (assuming a substantial therapy relationship has been established, not for short-term treatment).
- I will inform you if your child does not attend the treatment sessions.

- At the end of treatment, I will meet with you to provide a general description of goals, progress made, and potential areas that may require intervention in the future.
- If necessary to protect the life of your child or another person, I have the option of disclosing information to you without your child's consent.
- You agree that my role is limited to providing treatment and that you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.).
- You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.
- If there is a court appointed evaluator, and if appropriate releases are signed and a court order is provided, I will provide general information about the child, which will not include recommendations concerning custody or custody arrangements.
- If, for any reason, I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $250 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

The signature(s) below indicate(s) I/we understand and agree to abide by the above conditions. By signing, I/we am/are also confirming that I/we have the legal standing (guardianship, right to make medical care decisions) to consent to the above-named minor child's mental health treatment.

_____ _____

Minor Patient Signature (if 12 years or over) Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

_____

Witness Signature