Orange County Health Psychologists, Inc.

Consent to Treatment for a Minor

Name of Minor:	**Date of Birth:**
Name of Parent or Guardian:	

Initial	
	Consent for Treatment: As the parent(s) or legal guardian of the minor child named above, I give my permission for this minor to receive psychotherapy and/or assessment services from the offices of Orange County Health Psychologists, Inc. I affirm that there are no court orders in effect that would prohibit me from consenting to the treatment of this minor child**.**
	Cancellations and Missed Appointments: I understand that therapy needs to take place on a regular basis to be effective and that the best results occur when appointments are consistently scheduled and attended. I agree to give at least 24 hrs. notice when cancelling or rescheduling an appointment. If I do not provide at least 24 hrs. notice, I agree to pay a cancellation fee of $75 and I understand that insurance cannot be billed for this fee. The late cancellation fee may be waived as a courtesy one time.
	Consent to Use and Disclose Your Health Information: Treatment includes collecting and maintaining information that the law calls "protected health information" (PHI). We need to use this information in our office to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or received our *Notice of Privacy Practices*, which explains in more detail what your rights are and how we can use and share your information.
	Agreement to Pay for Professional Services: I agree to pay the per session fee of $_____ for the initial session and $_____ thereafter. I accept responsibility for payment although other persons or insurance companies may make payments on my account. If my treatment is covered by my insurance plan, and Orange County Health Psychologists, Inc. is not a contracted provider within my plan, I agree to pay the difference between the contracted rate and the amount paid by my insurance company. If my insurance company pays Orange County Health Psychologists, Inc. directly, I assign payment or benefits to their office. I understand that if payment is not made, my treatment may be terminated.

I have read and understand all the terms and conditions stated above regarding therapy. All of my questions have been answered. My signature below shows that I understand and agree with all of these statements.

Signature of Parent or Guardian:	**Date:**

I have discussed the terms of therapy with the client and/or representative. My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent. A copy of the *Notice of Privacy Practices* has been given to the client.

Provider Signature:	**Date:**

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