

# MICHAEL N. GARCIA, L.P.C.

**CHILD PATIENT INFORMATION & CONSENT** Welcome to my practice. The following is important information about your child's treatment. Please read and sign this document to indicate that you have reviewed the information and consent for your child to receive psychotherapeutic care.

**I. Length and Frequency of Treatment** Child psychotherapy involves regular 45-minute sessions for your child, in addition to separate parent consultations scheduled for every four to six weeks. The duration and frequency of treatment vary depending upon the nature of the concerns and needs. Ideally, there is a beginning, middle and an end to the work that we can consider and define together. When ending your child's treatment, it will be important for us to make a clear and thoughtful plan that assists your child in saying goodbye and facilitates their developmental momentum after treatment. If there needs to be a change in the schedule (i.e. someone is sick, vacation, an unexpected emergency), it is helpful to your child that we prepare them when possible. Minimizing abrupt changes and making plans for necessary changes in the schedule contributes to your child's confidence in the reliability of our work together.

**II. Method of Treatment** Children show what is on their minds through their play, art, words and behaviors, and are invited to do so in their sessions with me. During your child's sessions, I will be working to better understand what the matter is that they are bringing and sharing my thoughts and observations with them. During parent consultations, we will consider general themes from your child's sessions while also making use of your observations outside of the sessions. This process of understanding together over time helps to facilitate your child's development and address matters of concern. In order to reduce a sense of expectation or judgment on children in therapy, I ask that parents refrain from asking their children what has been discussed in the sessions, that children not be reminded or requested to discuss certain themes with me and that they not be told how to behave during the session. There may be times your child does not want to come to the sessions, and this is welcome. All that a child brings into the therapy is useful for understanding their predicaments and can be used to help them grow and make sense of it.

**III. Confidentiality and Privacy** As a rule, I will not disclose any information about your child's treatment without your written consent. My formal Mental Health Record describes the services provided to your child and contains such information as dates of sessions, diagnosis, functional status, symptoms and progress. I will require your permission in advance to disclose any information regarding treatment. You may authorize this exchange of information by signing an Exchange of Information form and revoke your permission at any time.

**IV. Limits of Confidentiality** There are some limits to the rule of confidentiality. Some exceptions I have created voluntarily and some are required by law. The following are exceptions to treatment confidentiality in which your written authorization is not required. In any of the following events of disclosure, I would make every effort to notify you prior.

**Emergencies** Protected health information may be disclosed in a life-threatening emergency situation. **Child Abuse** If I have reason to suspect that a child is abused or neglected, I am required by law to report the matter immediately to the Department of Social Services. **Adult Abuse** If I have reason to suspect that an elderly or incapacitated adult is abused or neglected, I am required by law to report the matter immediately to the Department of Welfare or Social Services. **Health Oversight** In the event that you or your child describes unprofessional conduct on the part of any mental health care provider, I am required by law to explain to you how to make a report of misconduct to the appropriate licensing board. I am required by law to report misconduct on the part of any mental health care provider of my own profession and reserve the right to report misconduct by any other type of health care providers. If you are a health care provider, I am required by law to report to your licensing board if I believe your condition places

the public at risk. **Court Proceedings [See also section “V”]** If your child is involved in a court proceeding and a request is made for your child’s records, such information is privileged under state law. I will not release records without your written authorization or a court order issued by a judge. If I receive a subpoena for records or testimony, I will notify you so that you, your attorney or I can file a motion to quash the subpoena. **Serious Threat to Health or Safety** Under state law, if I am engaged in my professional duties and you or your child express a specific and immediate threat to cause serious bodily injury or death to an identifiable person, and I believe that there is an intent and ability to carry out that threat immediately or imminently, I am legally required to take the steps to protect third parties. These precautions may include (1) warning the potential victim(s) or their parent/ guardian (2) notifying a law enforcement officer, or (3) seeking you or your child’s hospitalization. By my own policy, I may also use and disclose medical information about your child when necessary to prevent an immediate or serious threat to your child’s health and safety. If your child becomes a party in a civil commitment hearing, I can be required to provide your child’s records to the magistrate, your child’s attorney or guardian ad litem, an evaluator of the local community services board, or law enforcement officer. **Payment** Protected health information will be used, as needed to obtain payment for health care services. This may include determining eligibility and benefits from an insurance company or other third party and filing claims for my compensation. In the event of delinquent account status, this may include preparing the account for submission to a debt recovery agency. **Records of Minors** According to state law, parents may not be denied access to their child’s records. Also, community services board evaluators in civil commitment cases have legal access to therapy records without notification of parents or child. **Required by Law** Protected health information may be used or disclosed to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law, and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. **Therapist’s incapacitation or death** In the event that I cannot contact you because of my sudden or unexpected injury or death, I have arranged that a colleague have access to my patient files and contact information. This colleague would help to arrange the continuity of your care.

**V. Legal Proceedings and Court Testimony** I do not provide forensic services. This includes and is not limited to expert witness Court testimony for child custody, parenting evaluations, divorce, adoption or criminal proceedings. In cases where I am issued a subpoena, my hourly fee will apply for any time related to the Court proceedings. If you are in need of forensic mental health services, I will help you find a qualified practitioner.

## **VI. Patient and Client Rights**

**Right to Request Restrictions** You have the right to request restrictions on certain uses and disclosures of protected health information. You also have the right to request a limit on the medical information I disclose to someone who is involved in your child’s care or the payment of your child’s care. If you ask me to disclose information to another party, you may request that I limit the information that I disclose. However, I am not required to oblige this request. To make a request, you must request in writing, stating (1) what information you want to limit (2) whether you want to limit my use, disclosure or both; and (3) to whom you want the limits to apply. **Right to Receive Confidential Communications by Alternative means and at alternative locations** You have the right to request and receive confidential communications of private health information by alternative means and locations. To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted. **Right to an Accounting of Disclosures** You generally have the right to receive an accounting of disclosures of private health information for which you have neither provided consent nor authorization. On your written request, I will discuss with you the details of the accounting process. **Right to Inspect and Copy** In most cases, you have the right to inspect and copy medical and billing records. To do this, you must submit your request in writing. If you request a copy of this information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain

psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative proceeding. **Right to Amend** If you feel that protected health information I have about your child is incorrect or incomplete, you may ask me to amend the information. To request an amendment, do so in writing, citing the reason for your request. I may deny this request in certain circumstances. **Right to a Copy of This Notice** You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. I reserve the right to make changes to my policies and to this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain an effective date. A new copy will be given to and I will have copies of the current notice available upon request. **Complaints** If you believe privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services. **Freedom to withdraw** You have the right to end your child's therapy at any time. If you wish, you will be given names of other qualified therapists.

**VII. Fees and Payment Policy** Invoices are processed on a monthly basis and payment is due in the form of a check or cash within 30 days. You can bring the payment to a scheduled appointment, or mail it to the address provided. Do not include your name on the return address information of the envelope. In cases of overdue balances and non-payment, treatment may be paused until reaching a resolution for the balance. In the event of a cancellation, please notify me at least 24-hours in advance to avoid being charged for missed sessions.

**VIII. Phone and Emergency Contact** If you need to contact me, please don't hesitate to leave a message on my voicemail [434-981-7249]. I check my messages throughout the day, but it may take me until the following business day to return your call. You can also email me with administrative concerns (i.e. scheduling). However, keep in mind that email is not guaranteed as a confidential method of communication and I will only discuss clinical concerns over the telephone and in person. In an emergency situation, call the Region Ten Community Services Board emergency services line at 434-972- 1800, call 911, or go to your nearest emergency room.

**IX. Physician Contact** Physical and psychological symptoms often interact. You are encouraged to seek medical consultation for your child when warranted. In addition, medication may sometimes be helpful for psychological problems in children. When appropriate, a referral will be arranged for a medication evaluation.

**X. Freedom to Withdrawal** You have the right to end your child's therapy at any time. If you wish, you will be given names of other qualified therapists. In these cases, I request that you give me prior notice so that we can all help to prepare your child for the transition.

**PARENT/ GUARDIAN INFORMED CONSENT** I certify that I have reviewed the above CHILD PATIENT INFORMATION. I have had the opportunity to ask questions about this information and I consent for my child to receive psychotherapeutic treatment under Michael Garcia, L.P.C.

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Parent/ Legal Guardian Date

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Patient Date

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EFFECTIVE 01 October 2021