

Marcie Scranton, MA, MFT
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424-652-8520

PARENT CONSENT

I/We, _____, do hereby consent to have my/our child/children, _____, receive counseling from Marcie Scranton, MFT. I/we may revoke this consent at any time.

The fee for a 50-minute session (therapy hour) is \$150.00, which is payable at the beginning of each session unless we make other arrangements.* Should your circumstances change, we will re-evaluate the fee. Scheduled annual increases may also occur. I do not charge for brief phone calls between sessions.

If you must cancel a session for any reason, it is necessary to do so at least 24 hours in advance to avoid a charge for the session. In the event I cancel a scheduled session with you within the same time period, I will provide a session at no charge. I expect to be able to contact you should an emergency prevent me from keeping our appointment.

I accept MHN and Cigna insurance. If you wish to bill another insurance company, I will provide an out-of-network monthly statement for you to submit to your insurer. However, I cannot guarantee that you will receive reimbursement. Responsibility for payment ultimately resides with you as per our agreement, as are any fees not reimbursed by your insurer or other third-party payer.* Be sure to check your benefits before treatment begins. Please be aware that insurance reimbursement may affect confidentiality (see #5 on the following page). If you plan to use benefits of your health insurance policy, please let me know in advance.

My phones are equipped with confidential voice mail. I will make every effort to return calls as soon as possible. In the event that you or your child/children are feeling unsafe or require immediate medical or psychiatric assistance, please call 911, or go to the nearest emergency room.

*In the case of a fee modification, we agree that your fee/copay will be _____.

Risks and Benefits:

Psychotherapy is a process in which we discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change. This can result in a number of benefits, including decreased anxiety, negative thoughts, self-sabotaging behaviors, and dependence on medication and addictive substances, as well as improved relationships, greater comfort in social, school, and family settings, and improved self-confidence. Of course, there is no guarantee that therapy will yield any or all of the benefits listed above. Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. During the therapeutic process, some patients may find that they feel worse before they feel better. This is often normal. Personal growth and change may be easy at times, but may also be slow and frustrating. Please address with me any concerns you have regarding your child's progress.

Psychotherapist-Patient Privilege:

Patient information is subject to psychotherapist-patient privilege. Typically, the patient is the holder of privilege. If I receive a subpoena for records or testimony, I will assert privilege on your child's behalf. To protect confidentiality, I will not voluntarily participate in litigation or custody dispute in which you are a party. Should I be compelled to appear as a witness in an action in which you are involved, you agree to reimburse me for time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual hourly rate.

Limits Of Confidentiality:

Communication between therapist and patient is both privileged and confidential. This means I generally cannot discuss cases with anyone without your authorization. However, a therapist has an ethical and/or legal obligation to break confidentiality under the following circumstances:

1. If there is intent to harm another person, I am legally bound to warn the authorities and/or the person, or the family of the person.
2. If you disclose that you, or someone you know, was in the past or is currently involved in child abuse, elder abuse, or abuse of a disabled or dependent person, I am legally required to make a report to the appropriate agency.
3. If there is a life-threatening danger to yourself, it is my duty to warn the authorities and/or your family members.
4. If you become involved in legal proceedings that concern your medical or mental health, you may be waiving some rights to confidentiality, and records may be subpoenaed. Questions regarding the limits of confidentiality under those circumstances should be discussed with your attorney.
5. If you seek insurance reimbursement, you may be waiving your right to confidentiality. If your sessions are covered by insurance, your insurer will require, at a minimum, a diagnosis and dates of treatment.

While it is my legal responsibility to report any incidents of suspected child, elder, and dependent adult abuse, intent to do physical harm to oneself or another, or threats to another's property, it is my ethical responsibility to help you through trying times.

Professional consultation is an important component of a beneficial psychotherapy practice. As such, I may occasionally participate in consultation with appropriate professionals. At no time will I reveal any identifying information.

A note about electronic communication: I make every effort to ensure confidentiality, regardless of the medium. However, please be aware that data breaches can occur over email and Skype, and that technological malfunctions can sometimes interfere with the flow of communication.

Patient Rights And Responsibilities:

In addition to rights of confidentiality, you have the right to end therapy at any time, for any reason you deem appropriate, without any obligation except for fees already incurred. You also have the right to question any aspect of treatment and to expect that, should I not meet your child's needs, I will refer appropriately. I may also end our relationship if there is a conflict of interest, if your child's needs are outside of my scope of competence or practice, or for nonpayment of fees. In most cases I will recommend that we have at least one or more termination sessions to facilitate a positive closure experience and give us an opportunity to reflect on the work that has been done.

You may also expect that I will maintain professional and ethical boundaries with you by not entering into any personal, financial or professional relationship that could compromise the therapeutic relationship.

I/we have read and understand the foregoing, agree with its terms, and consent to treatment with Marcie Scranton, LMFT.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

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Child's Name _____ D.O.B. _____

Address _____ City _____ ZIP _____

Referred by _____

Parents' Names _____

Marital Status _____

If unmarried, is there a custody order in place? _____ (A copy will need to be provided)

Parents' Phone Numbers:

Home _____ Cell _____ Work _____

Home _____ Cell _____ Work _____

(Please circle your preferred contact number.)

Are there any restrictions on leaving messages? Yes _____ No _____

Other Children and ages _____

Parents' Occupations _____

Employers _____

Previous Psychotherapy (with whom and when) _____

Psychiatric Hospitalizations (date and reason for admission) _____

Has the child made a suicide attempt or expressed any suicidal thoughts? Yes_____ No_____

Please list any medications and purpose of each: _____

Please indicate any of the following that currently apply:

Headaches

Digestive Problem

Sleep Problems

Fatigue

Dizziness

Panic Attacks

Depression

Nightmares

Explosive Anger

Memory Problems

Anxiety

Injuries/Accidents

Poor Concentration

Disordered Eating

Allergies

Other: _____

Why are you seeking therapy at this time? _____

If therapy is helpful, how will your child's life change? _____

Please list any other information you feel is important for me to know, including unusual developmental milestones (walking, speech, etc.), academic and/or social issues, or other circumstances or events that may be having an impact on your child:
