Marcie Scranton, PsyD, MFT
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424-652-8520

PARENT CONSENT

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

Fees and Cancellations:
The fee for a 50-minute session is $225.00, which is payable at the beginning of each session unless we make other arrangements.* Longer sessions are charged on a pro rata basis. Sliding scale fees may be re-evaluated should your circumstances change. Scheduled increases may also occur with advance notice. I do not charge for brief phone calls between sessions. Telephone and video sessions are billed at the usual fee.

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

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. If you have arrived at my office for a scheduled session and I am not able to see you at that time, I will provide a session at no charge.

For clients wishing to bill insurance:
I accept Cigna insurance. If you wish to bill another insurance company, I will provide a superbill 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; this includes a standard $50 charge for a late cancellation or missed appointment.* Be sure to check your benefits before treatment begins. Copay/coinsurance and charges against deductible vary, and may change during the course of treatment. I will make every effort to avoid you being presented with unexpected charges. Please be aware that insurance reimbursement may affect confidentiality (see #5 on page 3). *If you do not plan to use your insurance benefits, please let me know.*
** Your copay/coinsurance (subject to EOB and any changes) _____.

Emergencies:
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.

Benefits and Risks of Psychotherapy:
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, and some patients may find that they feel worse before they feel better. This is often normal. 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.

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 need to 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. The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Those who do not have or are not using insurance have the right to receive a "Good Faith Estimate" explaining how much your medical care may cost, excluding non-emergency services, at least 1 business day before your services begin. For more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

Electronic Communication and Teletherapy:
If and when teletherapy is an option, the same rights and exceptions regarding confidentiality, fees, and responsibilities as in-person sessions apply. I provide a secure platform for virtual sessions and take care to conduct phone or video sessions in a protected space. However, sessions may occur in areas such as a patient's home, where others may be present. Please be aware of your surroundings. Information that may be significant, such as body language, may not be as easily communicated as it is in person. In addition, transmission difficulties sometimes occur, so I ask that we have a backup plan to keep things as uninterrupted as possible, for example, by switching to a different medium if necessary. I may need to verify your identity and location at the beginning of sessions. I do not record any teletherapy sessions without your express written consent.

To further ensure your confidentiality, I recommend that emails, texts and other traceable information not contain any sensitive material.

If you are planning to use your insurance, please check your coverage, especially out-of-network.

I/we have read and understand the foregoing, agree with its terms, and consent to treatment with Dr. 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: _____ _____

Parents' email: _____ _____

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:

_____

_____

_____

_____

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