well baby center®

Consent To Treat Minor

Please read carefully

This is to certify that I give permission to Well Baby Center (WBC) for my family or child's participation in therapy. Please fill out Consent to Treat Minor form for each minor participating in family or individual therapy

Child's Name: _____

DOB: _____/_____/_____ Sex: _____ Age: _____

Child's primary address: _____

Please list any medications minor is on: _____

Primary Care Dr: _____

Date late seen: _____ Phone: _____

Psychiatrist: _____

Date late seen: _____ Phone: _____

School: _____ Grade: _____

Adolescents and Children: Adolescents and children in individual therapy will be afforded confidential treatment. Because trust is an important therapeutic issue, parents will be provided with general progress information only. No other information will be given unless it is determined by the therapist to be in the child's best interest to do so. It is also imperative that treatment of children not be terminated abruptly. By signing the consent for treatment of a minor, you are agreeing to provide WBC with a minimum of thirty days notification of your intent to terminate your child's treatment, and also allow for at least two pre-termination sessions in order to adequately process the termination with the child.

In case of emergency: _____

Relationship: _____ Phone: _____

Any issues concerning Divorce, Custody, Guardianship, Probation and/or Restraining Orders will require all documents to be presented on first visit to verify any legal issues and/or custody of child. Copies of these documents will be kept with minor's records.
Please circle all that apply to minor and family: Divorce Legal Separation Custody Guardianship
Restraining Orders Current Litigation Issues Probation

Services may include, but are not limited to, psychological assessment, evaluation, and counseling. I understand this authorization may be revoked in writing at any time. This authorization is effective for one year after date of signing unless stipulated below:
Effective date: _____ End date: _____

1. **Information about your Therapist Training and Supervision**

WBC is a training center for Masters or Doctoral level counseling and psychology therapists and for paraprofessionals. All therapists are under the direct supervision of Clinical Supervisor/Clinical Coordinator. The therapist may consult, with other licensed mental health professionals for the purpose of supervision/education. Consultation is intended to ensure that the client receives the highest quality treatment. Finally, there may be circumstances in which the therapist needs to consult with other professionals, such as the client's physician, regarding the client's care. In such cases, the therapist will request the client's written permission to do so. In order to ensure that therapists receive the best training and that clients are well served, some sessions will be audio taped or viewed through a one way looking glass window. Audio tapes are used in supervision by Clinical Supervisor/Clinical Coordinator and therapist for clinical supervision only and are erased in a timely manner. There will be advance notice of a taping or viewing and it will be with your full and complete awareness. You must agree to have your family/child's sessions audio taped or viewed in order to receive services at WBC.

The therapist who is assigned to you is on a time limited contractual basis with WBC. Therefore, it is possible that the therapist may leave WBC prior to the end of therapy. If this does occur WBC will do everything to ensure a smooth transfer to another therapist.

2. **Confidentiality**

The therapist is legally prohibited from revealing to another person that the client is in therapy with them, nor can the therapist reveal what the client has said in any way that identifies the client without the client's written permission except with WBC staff and supervisor. There are some instances however, in which the client's right to confidentiality must be set aside as required by law or professional guidelines. These include the following:

- Instances of suspected abuse or neglect of a child, an elder, or a dependent adult must be reported to the appropriate protective services agency.
- If the therapist has reason to believe that your child or a member of your family poses an imminent danger of violence to another person, a serious intent to harm him/herself, the therapist must take steps to protect whoever may be in danger.
- To ensure a positive therapeutic relationship between a therapist and child client, the content of a child's session will remain confidential. While the child client's parent or guardian has a legal right to the content of the child's sessions, the therapist will speak with the parent/guardian in general terms about the content unless there is a concern about your child's safety.
- Well Baby Center cannot guarantee confidentiality with the use of electronic communications such as cell phones or email. Although we make every effort to maintain your confidentiality, if you agree to be contacted by your therapist using these methods of communication, you agree to these limitations on confidentiality. Unless otherwise indicated, your signature below will indicate that you consent to be contacted via cell phone and email.

3. **Cancellation Policy**

Your appointment time is reserved for you. You are required to pay for your sessions unless a 24-hour notice is provided WBC.

4. **Fees and Appointments**

Appointments are 50 minutes and ordinarily take place one time a week. Your family/child's specific hour is held by their therapist from week to week. If your family/child is unable to keep an appointment please contact their therapist to cancel as soon as possible. During your initial appointment you will be assigned a fee for your weekly session. WBC asks that you pay your therapist at the beginning of each session on a weekly basis. WBC reserves the right to suspend therapy for service rendered and not paid for after three sessions or after 30 days. Uncollected fees for three or more sessions may result in an interruption in therapy until the balance is paid in full. Any longstanding unpaid balances may be referred to a collection agency. If this should become necessary, the client will be notified in writing beforehand. There will be a $14 service fee for any returned checks. In the event of a medical emergency or an emergency involving a threat to the client's safety or the safety of others, please call 911 to request emergency assistance. Clients will also be billed at their regular hourly rate for administrative paperwork that the client has requested his/her therapist complete. Such paperwork can include, but is not limited to, letters to insurance companies, letters to state disability agencies, or forms required for reimbursement or coverage of treatment costs. If client's insurance covers completion of such administrative tasks, the insurance company will be billed.

5. **Minors left Unattended**

Minors must never be left unaccompanied. If your minor child has an appointment with a clinician, please make sure you accompany the child to and from his/her appointment. We ask that you not leave the premises when your child is at WBC, but if you do, please return at least fifteen minutes prior to the end of the child's appointment. If you will not be present on the premises during your child's session, WBC front office staff must be notified and given your contact information.

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6. **Acknowledgement**

By signing below, the client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. The client has discussed the terms and conditions of this Agreement with the therapist, and has had any questions with regard to its terms and conditions answered to the client's satisfaction. The client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with the therapist. In addition, the client agrees to hold the therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment. Therapy involves a partnership between therapist and client. Your therapist will contribute knowledge, skills, and a willingness to do their best.

I, _____ the undersigned parent, and the person having legal custody or guardianship/authorized care provider of _____ (the minor), do hereby authorize Well Baby Center (WBC), to provide psychotherapy for my minor child(ren).

It is without pressure or coercion that I sign this consent:

Please print your name and provide your signature:

Signature: _____ Date: _____
(parent/legal guardian/authorized care provider)

Signature: _____ Date: _____
(parent/legal guardian/authorized care provider)

Witness: _____ Date: _____

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Child and Family Developmental Questionnaire

Date:_____

Child's Name: _____Date of Birth: _____Age: ___

Mother's Name: _____Age: _____ Occupation:_____

Father's Name: _____ Age: _____ Occupation: _____

Marital Status: _____ Home Phone: _____

Mother's Cell phone:_____ Father's Cell phone:_____

Mother's Work phone:_____ Father's Work phone:_____

Emergency Contact (Name & Phone): _____

Is it okay to leave a message at all these numbers? Yes:___ If not, which if any? _____

Sibling's Name: _____ DOB: _____ Age: _____

Sibling's Name: _____DOB: _____ Age: _____

What concerns if any do you have about your child? _____

_____

_____

_____

What have you done to address the concern(s) so far?

_____

_____

Have any professionals been consulted (include any previous assessments, reports, etc.):

_____

Primary Pediatrician: _____

Developmental Pediatrician: _____ Phone: _____

Neurologist: _____ Phone:_____

Other: _____

_____

_____

Child and Family Developmental Questionnaire

Developmental History

Pregnancy and Delivery

Length: _____ months? Was the timing of the pregnancy good for you? _____

Any complications during pregnancy? _____

Any medications taken during pregnancy? _____

How did you feel about the pregnancy? _____How did your

Partner/spouse feel about the pregnancy? _____

What was your mood during pregnancy? _____And after? _____

Type of delivery? _____ Birth Weight? _____Complications? _____

_____

Emotional reaction to child? _____

Baby's temperament? _____

Breast-fed? _____ Bottle-fed? _____How did weaning go? _____

Problems with feeding? _____ Problems with sleeping? _____

Problems in the marital relationship? _____

Developmental Milestones

Sat up at _____ Crawled at _____Walked at_____

First words_____ Spoke in sentences_____

Toilet training accomplished (yes/no) _____at_____ Difficulties? _____

Medical History

Chronic Illness_____ Hospitalization_____ Surgeries_____

Ear infections _____ Strep _____ Allergies_____ Asthma_____

Other_____

Family History

Have any immediate or extended family members experienced an of the following:
(Circle all that apply)

Anxiety	Bi-Polar Disorder
Depression	ADD/ADHD
Alcohol/Substance Abuse	Schzophrenia/Psychotic Disorder

Child and Family Developmental Questionnaire

Childcare or Preschool

Preschool_____Telephone_____Director_____

Teacher_____Time/Days_____

Age started_____ Reaction to separation/and process_____

_____

Relationship with teachers/caregivers _____With other children_____

Concerns of teachers/caregivers_____

General

Does your child either seek-out, avoid, or over-react to: noises? ____ bright lights? _____

touch ? _____ smells? _____ food textures?_____ clothing?_____

movement?_____

Have there been any long separations, losses, exposure to extreme family conflict or traumas, etc. in your child's life? Please describe: _____

_____

Please describe your child's personality: _____

_____

Please describe your child's relationship to you:

Mom_____

_____

Dad_____

_____

Describe your parenting style. What is your attitude toward discipline and structure?

_____

_____

Describe your comfort level with an expression of a range of feelings?

Mom _____

_____

Child and Family Developmental Questionnaire

Dad _____

_____

How well do you and your partner co-parent together?

Mom _____

_____

Dad _____

_____

What does your child like to do? _____

_____

_____

What does you child not like to do? _____

_____

Describe your child's ability to handle:
Separations _____

New situations and people_____

Frustration_____

Limit Setting_____

Transition times_____

Expressing him/herself emotionally _____

Soothing him/herself _____

Recovery from distress _____

Self-Care (dress, feed, brush teeth, use toilet, etc.)_____

Do you have concerns in the following areas:
Making eye contact _____

Answering to his name_____

Arching back when being held_____

Child and Family Developmental Questionnaire

Excessive crying_____

Not pointing or mutually engaging_____

Fine motor skills _____Gross motor skills_____

Sleeping_____

Eating_____

Aggression _____

Behavioral concerns _____

Temper tantrums _____

Social interactions with peers_____

Social interactions with adults_____

Passivity or lack of interest in things_____

Other _____

At approximately what age did your child begin to…Point at things_____

Coo and babble_____ First words _____ Name things_____

Combine two words _____Use short sentences_____

Ask questions _____ Answer questions_____

Imitate movements _____ Identify needs_____

Please describe your child's feeding and eating development (picky eater, aversions, chewing or swallowing difficulties or allergies):

_____

_____