Sally Markley, LPC
Counseling Services 4737 E. Camp Lowell Dr. 520-903-8877

Consent for Treatment (on Behalf of Minor) Name: DOB: .

I understand that my minor child will be engaging in psychotherapy with Sally Markley, ATR, LPC. The purpose of this treatment is so that my child feels better or resolves specific life or adjustment problems that have caused me to assist my child in seeking assistance. The primary procedures used by Ms. Markley are "talk" therapy and art therapy, which is the utilization of the creative process of art making to improve and enhance my child's physical, mental, and/or emotional well being. I understand that she may also provide general education about mental health conditions or coping strategies. She may also assign "homework" for my child to do in between sessions. The potential benefit of treatment is that my child will feel better about his or her life, learn to manage stress, experience relief from painful emotions, or resolve problematic issues. I understand that a "cure" is not guaranteed and that it is possible that as my child talks about some things, he or she may even feel worse. He or she may experience emotions more intensely as he or she talks about things that are upsetting, or I may notice more conflict in relationships as my child make changes.

I understand that all information my child shares will be kept confidential, but that this confidentiality is not absolute. In the case of medical emergency, child/elder abuse or neglect, suicidal or homicidal intent, or under court order, clinical information may be released. I also understand that if my treatment is paid for by an insurance company, Ms. Markley will release clinical information to my insurer. In such cases, only that information required for billing will be released. Finally, I understand that Ms. Markley my child, and I will discuss and agree upon the extent to which information my child provides to Ms. Markley is shared with me.

I understand that as an independently licensed professional counselor in Arizona Ms. Markley is not obligated to receive clinical supervision. However, in an effort to provide services that reflect best practices, she may belong to a consultation group composed of other therapists that meets regularly and/or may consult individually with experts. I understand that if Ms. Markley discusses my child's case with a consultation group or with an expert practice consultant identifying information is kept confidential to the extent necessary. Also, from time to time, emergency coverage may be provided by colleagues of Ms. Markley and when this occurs she may disclose certain information as necessary to ensure appropriate coverage for my child.

I understand that I can receive a copy of my child's records or have a copy of my child's records provided to another person by completing a Release of Information form.

I understand that both my child and I have the right to participate in treatment decisions and that Ms. Markley and my child will together develop and periodically review and revise a treatment plan which will identify goals for treatment as well as the means of achieving those goals. I understand that I have the right to refuse any recommended treatment and that I may withdraw my consent to treatment at any time with no consequences.

I understand that Ms. Markley utilizes a billing company to bill my insurance company at the standard fee of $120 per 60 minute session and will accept insurance payments as partial payment towards this fee. I will be responsible for paying the agreed upon co-pay for each session covered by the insurance. Any excess insurance payments to Ms. Markley will be credited to my account and any insurance payments sent to me will be remitted to Ms. Markley up to the amount of my unpaid balance. I understand that I will be billed for cancelled sessions unless I give Ms. Markley 24 hour notice and that since most insurance companies will not pay a missed session fee I will be responsible for paying this fee. I understand that my insurance company is under contract with me and/or my employer and not with Ms. Markley, that I am ultimately responsible for all charges incurred for therapeutic services, and that Ms. Markley may use a collection agency if fees are not paid within a reasonable time frame. I may pay by check, cash or charge card. I acknowledge that if I choose to pay with a charge card, I will be charged an additional fee of 2.75% per charge.

I have read the above information and consent for treatment.

Signature of Parent/Guardian:_____ Date:_____

Witness:_____ Date:_____