Tanya Peters, Ph.D.
Licensed Clinical Psychologist PSY25046
Santa Monica, CA 90403
Phone: (310) 461-4425

CONSENT TO TREATMENT OF MINOR

WELCOME**:** Psychotherapy is unique in that it is highly personal work and, at the same time, involves a contractual agreement. It is important that you have a clear understanding of how the therapeutic relationship can work and what each of us can expect.

LIMITS OF CONFIDENTIALITY: Therapy sessions between a psychologist and a patient are strictly confidential (barring supervision/consultation by a licensed psychologist) except under certain legally defined situations involving threats of self-harm or harm to another, and cases of child abuse, elder abuse, or abuse of otherwise dependent individuals. In the case of self-harm, I am ethically bound to inform those in a position to help, or to otherwise enlist methods to prevent self-harm or suicide. In the case of danger to others, I am required by law to notify the police and to inform any intended victim(s). In instances of child abuse, elder abuse, or dependent abuse, I must notify the appropriate social service agencies. Other situations that require me by law to reveal information about you to others without your permission include a legitimate subpoena by a court of law if you are being treated or tested by court order.

PSYCHOLOGICAL SERVICES: Psychotherapy has both benefits and risks. The benefits are specific to each individual and may include the resolution of specific concerns that led you to seek therapy, lessening of distressful feelings, symptom reduction, and improved relationships with others. Working toward these benefits requires active involvement on your part. Remembering or talking about unpleasant events, feelings, or thoughts may result in experiencing discomfort and strong feelings. For these reasons, it is possible to experience an increase in symptoms during the course of treatment.

COORDINATION OF CARE: It is often helpful to address mental health concerns through multiple methods of treatment (i.e., therapy and medications). It is your duty to notify me, both at the outset of treatment and ongoing, if your child is receiving treatment of any kind which relates to our work together. If I determine that communication between me and your other providers would be beneficial, I may ask you to sign a “Release of Information” form granting me permission to release or exchange information and records pertaining to you and your treatment.

PAYMENT AND FEES: Together we will decide on an appropriate fee, which I will expect you to pay before the end of each session, or on a schedule otherwise agreed upon. If you wish to pay monthly, I will give you an invoice at the end of each month. If you wish to pay by check, please make it payable to: Tanya Peters, PhD. You are financially responsible for any fees/charges associated with returned checks.

APPOINTMENTS AND CANCELLATION POLICY: Individual sessions are 50 minutes in length. The time scheduled for your appointment is assigned to you and you alone. *If you need to cancel or reschedule a session, I ask that you provide me with 48 hours notice, or you will be financially responsible for the missed session. Provided I have another appointment time available, you may reschedule for another time during the same week without charge. However, this courtesy is intended for the occasional, not the habitual, need to reschedule.*

TERMINATION: You have the right to terminate therapy at any time; however, planned termination can be a valuable part of the therapeutic process. For your benefit, I request that we have at least two in-person termination sessions to process the ending stages of treatment, assess progress, and address issues related to follow-up care or referrals.

HOW TO CONTACT ME: If you need to contact me between sessions, you may leave a message at any time of the day or night at (917) 903-4454. Please be aware that I cannot always be reached by phone immediately, however, I will make every effort to respond to your call in a timely manner. If an emergency arises and you need immediate assistance, call 911, or go to the nearest Emergency Room and inform them that you are in crisis.

If you have any questions regarding the above or any related issues, please mention them. If not, please sign and date below indicating that you have read, understood, and voluntarily agreed to the above conditions.

Parent/Guardian Consent To Treatment

Child

Last Name:_____First:_____ Age:_____

(If you have sole legal custody please provide documentation, otherwise, both parent's signatures are required for treatment)

Parent/Guardian

Last Name:_____First:_____

Address:_____

City:_____State:_____Zip:_____

Cell Phone:_____Work Phone:_____

Email:_____May we email you?

2nd Parent/Guardian

Last Name:_____First:_____

Address:_____

City:_____State:_____Zip:_____

Cell Phone:_____Work Phone:_____

Email:_____May we email you?

1st Legal Guardian's Signature_____Date_____

(please print name)_____

2nd Legal Guardian's Signature_____Date_____

(please print name)_____

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NEW PATIENT FORM (MINOR)

Date _____

Child's name _____

Date of Birth_____

Gender _____

Address _____

City, State, Zip _____

Person to Notify in Case of Emergency _____
Relationship to child

Address _____ Phone _____

Has child ever received mental health treatment? ____ Yes ____ No

Who is his/her primary physician?

_____
Name Phone Number

Please list any medications he/she is currently taking

_____

Please describe your reason(s) for seeking treatment at this time. If there is a particular event which triggered your decision to seek treatment now, please list the event:

_____

_____

_____

CREDIT CARD CONSENT & AUTHORIZATION FORM

Dr. Peters' fee is $350 per 50 minute session.

I, _____, hereby authorize Tanya Peters, Ph.D to keep my signature on file and to automatically charge my credit card account as indicated below:

X for recurring charges (ongoing treatments) until Patient is formally discharged as a patient from the office of Tanya Peters, Ph.D. unless I revoke such authorization in writing beforehand.

X for missed/cancelled charges with less than 48 hours advance notice until Patient (named below) is formally discharged as a patient from the office of Tanya Peters, Ph.D. unless I revoke such authorization in writing beforehand.

PATIENT NAME: _____

CARDHOLDER NAME (As printed on card):

_____

ACCOUNT NUMBER: _____

EXPIRATION DATE: ____ /____/____

CARDHOLDER BILLING Zip code:_____

SECURITY CODE:
MasterCard/VISA (3 digits in back):_____

American Express (4 digits in front): _____

CARDHOLDER SIGNATURE: _____DATE: ____/____/____

A photocopy or facsimile of this signature is as valid as the original.

NOTICE OF USE OF PRIVATE HEALTH INFORMATION

Effective Date: April 14, 2003

FOR YOUR PROTECTION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR HEALTH INFORMATION IS PRIVATE

Keeping your health information private is one of our most important responsibilities. We are committed to protecting your health information and following all laws regarding the use of your health information. The laws say:

1. We must keep your health care information from others who do not need to know it.

2. You may ask that we not share certain health information. (In some instances we may not be able to
agree with your request.)

WHO SEES MY HEALTH INFORMATION?

Your private health information may be used by the health care providers (such as substance abuse treatment counselors, mental health providers, doctors, nurses, etc.) who take care of you. We need this information in order to plan your care. When appropriate we may share health information about you in order to help you get the services you need. We may also use your information to contact you about appointment reminders or to tell you about treatment alternatives.

MAY I SEE MY HEALTH INFORMATION?

You may see your health information unless it is the private notes taken by a mental health provider or it is part of a legal case. Most of the time you may receive a copy if you ask. You may be charged an amount to cover copy costs.

If you think some of the information is wrong, you may ask in writing that it be changed or that new information be added. You may ask that the changes or new information be sent to others who have received your health information from us. You may ask for a list of any places where health information has been sent, unless it was sent for treatment, payment, quality review, or to make sure we are following the laws protecting your privacy.

WHAT IF MY HEALTH INFORMATION NEEDS TO GO SOMEWHERE ELSE?

You may be asked to sign an authorization form allowing your health care information to go somewhere else if:

1. Your health care provider needs to send it to other places;
2. You want us to send it to another health care provider; or
3. You want it sent to another person for you.

The authorization form tells us what, where and to whom the information must be sent. Your authorization is good for six (6) months or until the date you put on the form. You can cancel or limit the amount of information sent at any time by letting us know in writing.
If you are less than 18 years old – your parents or guardians will receive your private health information, unless by law you are able to consent for your own health care treatment. If you are, then your private

health information will not be shared with parents or guardians unless you sign an authorization form. You may also ask to have your health information sent to a different person that is helping you with your health care.

COULD MY HEALTH INFORMATION BE RELEASED WITHOUT MY AUTHORIZATION?

When private health information is released without an authorization, it is normally used for Treatment, Payment or Operations (managing the business of a health care provider and reporting to agencies that oversee our business, such as state regulators). The release of health information for this purpose is not tracked and we are not accountable to you for it. Any other release made without your authorization is accounted. We always report:

1. Contagious diseases, birth defects, and cancer
2. Reactions and problems with medicine
3. Victims of abuse, neglect or domestic violence
4. To the government agency that oversees our business
5. To prevent serious threat to your or others' health and safety
6. Work-related injuries

7. Out of state offenders

8. As required by court order and/or subpoena

9. If you commit a crime on the premises

HOW CAN I FIND OUT IF MY HEALTH INFORMATION HAS BEEN RELEASED WITHOUT MY AUTHORIZATION?
To find out if your health information has been released without your authorization for purposes other than Treatment, Payment or Operations, contact Tanya Peters Ph.D. at 2730 Wilshire Blvd., Suite 650, Santa Monica, CA 90403 and ask for a Request for Accounting of Disclosures form. Simply fill out the form, attach a copy of your most recent picture ID, and send both to: Tanya Peters Ph.D. at 2730 Wilshire Blvd., Suite 650, Santa Monica, CA 90403

MAY I HAVE A COPY OF THIS NOTICE?

This notice is yours. If we change anything in it, you will get a new notice. You can obtain additional copies of this notice by asking your health care provider.

QUESTIONS OR COMPLAINTS?

If you have questions about this notice or you think that we have not protected your private health information and you wish to complain about it, please contact: Tanya Peters, Ph.D. at (917) 903-4454.

You can also complain to the Federal Government by writing to the: Office for Civil Rights

U.S. Department of Health and Human Services 200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201-0004
Or by calling the Office for Civil Rights at (800) 368-1019

By signing this form, you are acknowledging that you have received a copy of this notice.

_____

Patient Signature/Date

_____

Therapist Signature/Date