M. Eticia Nademin, Ph.D.

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CONSENT AND ASSENT FOR TREATMENT OF A MINOR CLIENT

Prior to beginning treatment, I will review with you terms of the general informed consent policy. Working with children, however, involves unique considerations. Therapy with youth involves many benefits but also, at times, risks. Psychotherapy is most effective when a trusting relationship exists between the clinician and the client. As the parent of the minor client, state law allows you the right to access information regarding your child's treatment and records. However, privacy is crucial in securing and maintaining that trust. While one goal of treatment is to promote a stronger and improved relationship between children and their parents, doing so often requires that children be allowed a "zone of privacy," whereby they feel free to discuss personal matters openly without worry that what they disclose will be automatically shared with their parents. Therefore, it is my policy to request an agreement between parents, minor, and myself in which parents consent to waive access to their child's treatment records. The purpose of this agreement is not to keep information about your child from you, but rather to give your adolescent a chance to explore problem behaviors and to learn more healthy ways of coping without fear of punishment. If you agree, I will provide you with only general information about the focus and progress of your child's treatment, as appropriate.

Your child, you, and I may not always agree regarding the best interests of your child; however, if disagreements occur, I will consider your perspectives thoroughly, and we will work together to resolve them in a way that enables and enhances your child's therapeutic progress. I make it a practice to encourage a minor to share important information with parents when clinically indicated, and with the minor's permission, I will do so also as the situation allows. Please be aware that the most common sensitive issues for teens include substance use and sexual relationships. Although these topics may not be applicable to your teen, if you have concerns about substance use I encourage you to consider drug testing your child before the start of therapy, as I may not be able to discuss such matters with you if I find them to be applicable to your child. If it is necessary to refer your child to another mental health professional with more specialized skills, I will also share that information with you and assist you with an appropriate referral.

Although my responsibility to your child may require involvement in conflicts between you, I request your agreement that the involvement be strictly limited to that which will benefit your child. This means, among other things, that you agree to refrain from using my involvement with your child as an attempt to gain advantage in any legal proceeding between you and a partner. In particular, this requires your agreement that you will not ask me to testify in court, in person or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done in working with your child. This agreement may not prevent a judge from requiring testimony from me. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information, as needed (if appropriate releases are signed or a court order provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me two times my hourly fee for time spent traveling, preparing reports, testifying, serving in attendance, and completing other case-related activities. Payment will require a retainer, in advance.

In the event that I feel your child is in imminent danger in which I believe disclosure to be necessary to prevent probable harm, I will notify you of my concern (please see below for further description of limits of confidentiality by Arizona state law). Ultimately, you will decide whether therapy will proceed. If you decide that therapy should be discontinued, I will honor that decision, though I ask that you allow the option of having a 1-3 closing sessions to appropriately end the treatment relationship.

Limits of Confidentiality by Arizona Law

I will inform you and appropriate helping professionals if any of the following situations arise in treatment:

- There is reasonable suspicion of actual or potential child neglect or abuse (including physical, emotional, or sexual abuse, the witnessing of domestic violence, or the victim of a crime; in these cases, I am mandated by Arizona law to disclose to the office of the Child Protective Services.
- Consensual intimate relationship of a child thirteen or younger with a partner of any age, or a child fourteen or older with a partner eighteen or older.
- The child communicates a direct, serious threat of physical harm to an identifiable victim or victims, in which case disclosure to the appropriate authorities is required by Arizona law.
- There is reason to believe that the client may be a danger to self, another, or another's property, and that disclosure and/or hospitalization is necessary to prevent that danger.
- A valid court order is received.
- For the purposes of consultation with colleagues; however, no identifying information will be released.

Consent and Assent for Treatment of a Minor Client

This form documents that my child and I have discussed treatment practices, including confidentiality and limits herein, with Dr. Nademin, and I give consent for my child to receive psychological services. I understand that I can revoke my consent for treatment in writing at any time. I understand that if I violate any provisions of this agreement, my treatment may be terminated. I also understand that this Agreement is binding in the State of Arizona and that the stated provisions are for my protection and that of Dr. Nademin. I have informed Dr. Nademin of any ongoing or pending legal proceedings I am (or could be) involved in. The original copy of this agreement will become a part of my private medical record.

My signature below indicates that I have read and understood the above agreement and give consent for my child, _____ to receive psychological services from Dr. Nademin. My child's and my signatures indicate that we agree to the above policy for treatment of my minor child.

_____ _____
(Parent's Printed Name) *(Date)*

_____
(Parent's Signature)

_____ _____
(Printed Name of Minor) *(Date)*

_____ _____
(Signature of Minor) *(Date of Birth)*

Payment Agreement/Cancellation Policy

I understand that all payments are due at the time of service. Dr. Nademin will provide me with a "Super Bill," if requested, which is a receipt that functions as a claim that can be submitted to my insurance company for possible reimbursement. I understand that there is a 24-hour cancellation/rescheduling policy, and that I will be charged $100.00 if a scheduled appointment is not cancelled with a minimum of 24 hours notice. Finally, I understand that due to scheduling needs of other patients, Dr. Nademin is not able to extend my session time if I arrive late to an appointment and that in such cases or in cases when I miss a session without advanced notice, I will be responsible for payment of the full session fee, $175.00.

_____ _____
(Parent's Signature) *(Date)*

CONTACT INFORMATION IF CLIENT IS A MINOR

If the client is a minor, please fill out the following:

Mother's Name_____ Home Phone _____

Work Phone _____ Cell / Pager _____

Address _____ City_____State _____Zip_____

Father's Name _____ Home Phone _____

Work Phone _____ Cell / Pager _____

Address _____ City_____State _____Zip_____

Contact Person in Case of Emergency: _____

Relationship_____

Telephone (_____) _____ Other Telephone (_____)_____

Please list names of step-parents or additional guardians, if applicable.

_____

_____

Are the client's biological parents still married? Y / N

If no, do the client's parents share legal custody? Y / N

Is the client adopted? Y / N

If yes, does the client know that he/she is adopted? Y / N

ARIZONA NOTICE FORM

Exhibit B: Notice of Protected Health Information Practices (Privacy Policy)

I understand that I am to read Dr. Nademin's privacy policy, which can be found under *New Client Paperwork* at www.aztherapeutic.com or at Dr. Nademin's office: 3040 E. Cactus Rd. Phoenix, Az 85032.

The privacy policy describes how psychiatric and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Exhibit C - Acknowledgement of Receipt of Privacy Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by M. Elicia Nademin, Ph.D., LLC (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address:
3040 E. Cactus Rd. Phoenix, Az 85032, Attention: M. Elicia Nademin, Ph.D., Compliance Officer

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (*leave blank if no restrictions*): _____
_____.

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

Acknowledgement of Receipt of Privacy Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

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BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF DR. NADEMIN'S PRACTICE POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS.

Patient's Name	**Date of Birth**
Social Security Number	
Name of Personal Representative (if applicable)	**Relationship to Patient**
Signature of Patient	**Date**
Signature of Parent/Guardian/Representative	**Date**

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____ Accepted **_____ Denied** **_____ Not Applicable**

_____Other (explain) _____

Signature of Authorized Practice Representative _____ Date _____