Therapy Agreement for Teen, Young Adult

ADDRESS: Offices in: Berkeley, San Francisco, Walnut Creek, Danville.

TIME: Session typically last approximately 50 minutes (the “therapy hour”).

FEE: My fee is $___________ per therapy hour. The fee is payable at the beginning of each session. Please make checks payable to: Thomas Gonda

CANCELLATION POLICY: I have a 24-hour cancellation policy. If you fail to cancel a scheduled appointment, I cannot use this time for another client and you will be billed for the entire cost of your missed appointment. You are responsible for payment if you cancel within 24 hours, or, if you fail to show up. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment within 24 hours. Please call me (510-495-4826) or e-mail me (tgondajr@earthlink.net) if you find it necessary to cancel or reschedule your appointment. Thank you for your consideration regarding this important matter.

SERVICES: Psychotherapy is a healthy, positive, supported exploration into the issues and challenges that you may encounter; psychotherapy often leads to better relationships, solutions to specific problems and reductions in negative emotions such as anxiety, anger and depression.

It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that we are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Due to the varying nature and severity of problems and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

CONFIDENTIALITY: The law protects the privacy of communications between a client and a psychotherapist. I am legally obligated as a mandated reporter to notify the appropriate authorities if a client gives me reason to believe that he or she may harm themselves or others, or if he or she is involved in, or has knowledge of, the abuse of a child or elderly person, or in cases of a court order. Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Example: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian. If you tell me, or if I believe based on things you’ve told me, that you are addicted to alcohol, I would not keep this information confidential.
Example: If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I will not keep this information confidential. You can always ask me questions about the types of information I would disclose. You can ask in the form of “hypothetical situations,” in other words: “If someone told you that they were doing _____, would you tell their parents?”

Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you. [You should also know that, by law in California, your parent/guardian has the right to see any written records I keep about our sessions. It is extremely rare that a parent/guardian would ever request to look at these records.]

GRIEVENCE POLICY: In the event of a disagreement, concern, dispute, grievance, compliment or complaint, please bring this to my attention as soon as possible.

TERMINATION OF THERAPY: The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referrals, changing your treatment plan or terminating your therapy.

EXPECTATIONS OF CLIENT: The client is expected to be honest and direct. There is an expectation that there will be only one therapist working with the client. The client is expected to follow the guidelines in this therapy agreement.

GENERAL CONSENT FOR CHILD OR DEPENDENT TREATMENT

I am the legal guardian or legal representative of the patient and on the patient’s behalf legally authorize the practitioner/group to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

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<th>Patient Name (Child, Minor, Dependent)</th>
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Signature (Client's Parent/Guardian/Legal Representative) ________________ Date ________________

___________________________
Relationship to Patient

Signature (Client’s Parent/Guardian/Legal Representative) ________________ Date ________________

___________________________
Relationship to Patient

Signature of Minor Client ________________ Date ________________

Therapy Agreement for adolescent, Informed Consent, 120105