NORTH SCOTTSDALE PEDIATRICS

CONSENT FOR TREATMENT

I authorize and request that Lauren Chatellier, MSW, LMSW, BHP carry out behavioral health treatment, and/or diagnostic procedures which now or during the course of my care are advisable.

I acknowledge that I have been provided with a copy of the notice entitled, “Your Personal Information with Lauren Chatellier, MSW, LMSW, BHP.” I authorize the use and disclosure of my information as defined in the notice.

I acknowledge that Lauren Chatellier, MSW, LMSW, BHP is a sole practitioner within North Scottsdale Pediatrics, under the clinical supervision of Leslie Pechkurow, LPC License No. LPC-14134.

_____ _____

Patient (or Parent/Guardian) Signature Date Signed

_____

Patient (or Parent/Guardian) Printed Name

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Safe Harbor Agreement

1. **Parties:** The Parties to this Agreement are _____ and _____ (together (the parents)

2. **Goal:** The therapeutic goal is to permit the child to have a safe place that they deem safe to be able to speak to a mental health provider about any apprehensions, concerns, or issues without fear that what they say will be used to interfere with or create problems with either parent.

3. **Safe Harbor:** In order to effectuate the stated goal, the parties acknowledge the importance of the therapist's office being a safe harbor- a place where the children can be truthfully assured that what they say will not be disclosed to third parties without their consent.

4. **Agreement:** Therefore, to create a safe harbor for the children, parties agree to the following:

    a. **No court/no depositions**: Neither parent shall, nor will either parent permit his or her attorney to, subpoena the therapist or her notes to trail, hearing, deposition, or arbitration.

    b. **No interrogations:** Neither parent shall, nor will either parent permit his or her attorney to demand answers from either the therapist or the children to questions about the content of the therapy

    c. **No disclosure:** The therapist agrees that she shall not divulge to either parent, to either attorney, to the judge or to any other third party any matter relating to the content of the therapy with child (except required disclosures under the Child Abuse Reporting Act, or other safety concerns) without the child's explicit consent.

    d. **Enforcement:** Any party, or his attorney, who seeks to interrogate or subpoena the therapist shall be liable for all attorney fees and costs incurred to resist answering discovery request or to quash a subpoena.

_____ _____
Parent Date

_____ _____
Parent Date

_____ _____
Therapist Date

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YOUR PERSONAL INFORMATION WITH
Lauren Chatellier, MSW, LMSW, BHP

Please read this notice describing how I handle information about you in compliance with state and federal law, describing your access to this information:

I. GENERAL CONSENT

With your signature on the Psychotherapy Agreement, you give me your general consent for treatment, which includes your permission for me to *use* and *disclose information (info)* about you for the purposes of *payment, treatment, and operations.*

Some Clarifications:

Information (*Info*) means information I keep that could identify you

Treatment means when I provide, coordinate, or manage your care. This includes activities such as consulting with your physician or another treatment professional. If I choose to consult with a colleague regarding your case, I do not reveal your identity and will note these consultations in your *record*.

Payment means when I disclose your *info* to obtain payment such as from a parent/guardian for counseling services I provide.

Operations refers to activities of operating my practices and business-related matters. North Scottsdale Pediatrics staff may have limited access to your *info* for the purpose of checking in/out your appointment with me, accepting payment for services I provide, and scheduling future appointments.

Use means using your *info* only with North Scottsdale Pediatrics.

Disclose means providing your *info* to others outside of my office with your consent.

Record refers to the files and/or electronic health records I keep for managing your therapy, except *psychotherapy notes*. Examples include the intake paperwork, billing, a diagnosis, and goals for treatment.

Psychotherapy Notes refers to notes I have made about our conversations for my own use in your treatment. I keep these notes in your behavioral health chart within North Scottsdale Pediatrics' electronic health records system, Athena. Your behavioral health chart is **separate** from your medical chart.

II. INFORMED CONSENT

Therapy is an interactive process between patient and therapist, and the results of therapy depend on your cooperation. It is meant to promote change and understanding. Sometimes this process can be emotionally painful, and at other times very fulfilling. You will be expected to contribute to all decisions regarding therapeutic interventions (including out of session assignments), treatments planning, and periodic treatment plan reviews. You have the right to refuse or alter any service and intervention. While the therapist will use best effort to assist you, the nature of psychological services is that there can be no assurances of results, and no promises can be made regarding the outcome of any services provided. You should question the rationale of any services, intervention, and discussion if these seem unclear to you.

III. AUTHORIZATION

An *authorization* is your signed, written permission which permits only specific disclosures above and beyond the general consent. When I am asked for *info* for purposes outside of payment, treatment and operations, I will obtain an authorization before releasing this information for your record or from my psychotherapy notes. You may revoke an authorization at any time, provided your revocation is in writing. However, you may not revoke an authorization to the extent that I have relied on it.

IV. USES AND DISCLOSURES WITHOUT CONSENT OR AUTHORIZATION

I may use or *disclose* your *info* without your consent or authorization in the following circumstances:

Child Abuse I am required to report to the appropriate authorities when I have reasonable grounds to believe a minor is or has been the victim of neglect or physical and/or sexual abuse

Health Oversight Activities If the Arizona Board of Behavioral Health Examiners is conducting an investigation, I may be required to disclose your *info* to them.

Judicial and Administrative Proceedings If you are involved in a court proceeding and a request is made for records and/or information about our work together, such information is privileged under state law and I will not release it without your written authorization, or that of your legally appointed representative, or a court order.

Serious Threat to Health or Safety If you communicate to me an explicit threat of imminent serious physical harm or death to a clearly identifiable victim (or victims) and I believe you have the intent and ability to carry out such a threat, I have a duty to take reasonable precautions to prevent harm from occurring. This may include *disclosing info* to the potential victim and/or to the police, and to initiate the appropriate hospitalization

procedures. If I believe that there is an imminent risk that you will inflict serious harm on yourself, I may *disclose info* in order to protect you.

V. MINORS AND PARENTS

Patients under the age of 18 years of age who are not emancipated, and their parents should be aware that the law may allow parents to examine their child's *record.* Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they give up their access. If they agree, during treatment I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's *authorization*, unless I feel that the child is in danger or presents a danger to someone else. In that case, I will notify the parent(s) of my concern. Before giving parents any i*nfo*, I will discuss the matter with the child, if possible, and do my best to handle objections that he/she may have.

VI. RECORD STORAGE

While you are an active client, your *record* is kept in a sealed behavioral health chart in North Scottsdale Pediatrics' electronic health records system. Your behavioral health chart is **separate** from your medical chart. Only myself, my clinical supervisor (Leslie Pechkurow, LPC), and your primary care provider with your consent, have access to your behavioral health chart. My *psychotherapy notes* are kept in a secure area within your behavioral health chart, with the only people having access to them being myself and on occasion, my clinical supervisor, Leslie Pechkurow, LPC. The records will be maintained and securely stored for seven years from the date of and last activity as a client.

If you wish to access your *record,* or you require information from your *record*, contact me, Lauren Chatellier, LMSW by calling my direct line at (480) 247-6365. I will assist you.

VII. EFFECTIVE DATE

This notice was revised and is in effect as of October 18th, 2018.

PSYCHOTHERAPY

Psychotherapy varies depending on the personalities of the therapist and client, and the problems being addressed. Often it involves difficult aspects of life and experiencing uncomfortable feelings. Beneficial results depend on the active effort on your part.

My approach to work with children and their families builds on *Attachment-Theory*, which places an emphasize on creating or strengthening a secure bond between parent and child. I may utilize elements of different treatment modalities in our work together, including but not limited to: *Behavior Modification, Parenting Skills, Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT) Skills, Therapeutic Play, Therapeutic Art, Psychodynamic, Motivational Interviewing and Family System*s. I tailor each treatment plan to the specific needs of your child/family, building on your child/family strengths to work through problems together, and working collaboratively with you to set S (specific) M (measurable) A (attainable) R (realistic) T (timely) goals for your child/family.

There are times when despite our mutual best efforts, therapy is not helpful. At times, a particular therapist or their approach to therapy may not be a good fit for the client/family. If at any time you feel that I am not a good fit or that therapy is proving to be ineffective, please let me know. I will offer to assist you in finding another behavioral health provider if needed.

LOCATION OF SERVICES

All behavioral health services will be provided at our **Ironwood office**, located at:

North Scottsdale Pediatrics
9827 N 95th St
Unit 105
Scottsdale, AZ 85258

CONTACTING ME

Messages can be left for me at the office number (480) 860-8488 ext. 1046. Unless we have specifically made other arrangements, I do not provide on-call phone or emergency sessions. In an emergency contact 911, a hospital emergency room or the Banner Behavioral Health Crisis Line (602) 222-9444. If you feel you require special support between our scheduled sessions, please discuss these needs with me.

SOCIAL MEDIA POLICY

This document outlines my office policies related to the use of *Social Media*. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet. If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

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FRIENDING

I do not accept friend requests from current or former clients or their families on any social networking site (Facebook, Linked In, etc.) I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blue the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet, and we can talk more about it.

INTERACTING

Please do not use cell phone text messaging or messaging me on Social Networking sites such as Twitter, Facebook, Instagram, Snapchat, Linked In, etc. to contact me. These sites are not secure, and I may not read these messages in a timely fashion. Do not use wall postings, @replies, or other means of engaging me in the public online if we already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become part of your behavioral health chart and will need to be documented and archived in your chart. If you need to contact me between sessions, the best way to do so is by calling the office at North Scottsdale Pediatrics, asking to be connected to my extension 1046. If I do not answer, you may leave me a message in my confidential voicemail box.

PARTICIPATION IN LITIGATION

I will not voluntarily participate in any litigation, or custody dispute in which the client and another individual, or entity, are parties. I have a policy of not communicating with client's attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in a legal matter. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed or ordered by a court of law to appear as a witness in an action involving a client, client agrees to reimburse me for any time spent in preparation, travel, and customary rate of $150 per hour.

I have read and understand the above terms of consent to treatment.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Therapist Signature Date

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ADOLESCENT CONSENT AND PARENT AGREEMENT TO RESPECT PRIVACY

What to expect:
The purpose of meeting with a therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems.

I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information.

There are however, important exceptions to this rule that are important for you to understand before you share your personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below:

Confidentiality cannot be maintained when:

- You tell me you plan to cause serious harm or death to yourself, or someone else who can be identified, and I believe you have the intent to and ability to carry out this threat in the very near future. I must take steps to inform a parent/guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself, and if applicable, I must inform the person who you intend to harm.

- You are doing things that could cause serious harm to yourself or someone else, even if you do not intend to harm yourself or another person.

- You tell me you are being abused physically, sexually, or emotionally or that you have been abused in the past. In this situation, I am required by law to report the abuse to the proper authorities.

- You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement unless the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

Communicating with your parent(s) and guardian(s):

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.

Communicating with other adults:

School- Sometimes, I may request to speak with someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone from your school wants to contact me, I will discuss it with you and ask for your parent/guardian's written permission.

Doctors- You are most likely seeing me, because your doctor referred you to me for behavioral health services or your parent/guardian prefers that you see me for counseling, because I have a close working relationship with your doctor. Your doctor and I may need to work together, for example, if you need to take medication in addition to seeing a counselor or therapist. By signing this, you agree in advance to allowing me to share information with your doctor.

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist.

Minor Signature: _____ Date: _____

Minor's Printed Name: _____

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Parent Agreement to Respect Privacy
Parent/Guardian:

Check boxes and sign below indicating your agreement to respect your adolescent's privacy:

____ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

____ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgement and may sometimes be made in confidential consultation with her clinical supervisor and/or my child's primary care provider when appropriate.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Therapist Signature: _____ Date: _____