MENTAL HEALTH TREATMENT OF A MINOR

AND

PARENT AUTHORIZATION

Though Dr. Federici is not required to follow *HIPPA (practice does not meet the criteria)*, he will maintain patient confidentiality, however, in some situations, Dr. Federici is required by law to disclose information if your child or someone else is in danger, similar to the exceptions to confidentiality for adults. The difference lies mostly with the disclosure of the minor's treatment information to parents. Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is Dr. Federici's policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to him without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then Dr. Federici will need to use his professional judgment to decide whether your child is in serious and immediate danger of harm. If he feels that your child is in such danger, Dr. Federici will communicate this information to you. By law, Dr. Federici does not have to disclose to you *a minor's sexually transmitted disease, termination of pregnancy, substance abuse, or any other information that in hi professional judgement may adversely affect the minors health or welfare*.

Example: If your child tells Dr. Federici that he/she has tried alcohol at a few parties, he would keep this information confidential. If your child tells Dr. Federici that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, he would not keep this information confidential from you. If your child tells him, or if Dr. Federici believe based on things he learns about your child, that your child is addicted to drugs or alcohol, Dr. Federici would not keep that information confidential.

Example: If your adolescent child tells Dr. Federici that he/she is having voluntary, protected sex with a peer, he would keep this information confidential. If your child tells him that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, he will not keep this information confidential.

You can always ask questions about the types of information Dr. Federici would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing _____, would you tell the parents?" If Dr. Federici believes that it is important for you to know about a particular situation that is going on in your child's life he will encourage your child to tell you, and will help your child find the best way to do so. Also, when meeting with you, Dr. Federici may

sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, Dr. Federici will strive to understand your perspectives and fully explain his perspective. Ultimately, parents decide whether therapy will continue. However, in most cases, Dr. Federici will ask that you allow him the option of having a few closing sessions with your child to appropriately end the treatment relationship.

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although Dr. Federici's responsibility to your child may require him helping to address conflicts between the child's parents his, role is limited to providing treatment to your child, unless the treatment is for family therapy. Regardless, you must agree that neither parent will seek to subpoena your child's records or ask Dr. Federici to testify in court, or to provide letters or documentation expressing his opinion about parental fitness or custody/visitation arrangements. Dr. Federici is hearing impaired and will no longer provide outside services. For these matters you should seek a separate individual to preform a custody evaluation.

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify Dr. Federici immediately. Dr. Federici will ask you to provide a copy of the most recent custody decree that establishes custody rights of you and the other parent. Unless the other parent has sole right to make such decisions, either parent has the right to bring their child for therapy in New Jersey.

PARENT/GUARDIAN OF MINOR PATIENT

Name of Child _____ **Child's Date of Birth** _____

With Whom Does Child Live?_____

Please initial after each line and sign below, indicating your agreement to respect your child'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 agree to allow my child to have a "zone of privacy" and I will respect the confidentiality of my child's/adolescent's treatment. _____ _____

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 Dr. Federici's professional judgment. _____ _____

_____	_____	_____
Signature of Parent or Guardian	**Print Name**	**Date**
_____	_____	_____
Signature of Parent or Guardian	**Print Name**	**Date**

If applicable, I also attest that I am the legal guardian and have the right to consent for the treatment of this minor

_____	_____	_____
Signature of Patient or Guardian	**Print Name**	**Date**

The undersigned agrees to be financially responsible for this account, and will pay promptly after each session.

_____	_____	_____
Signature of Patient or Guardian	**Print Name**	**Date**

_____	_____	_____
Relation	**A ddress**	**Phone**