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Child Psychotherapy Services Contract

[Info in brackets [] is my commentary]
[This is typical but is modified to fit the individual case situation]

I, _____ hereby grant permission to Dr. _ to provide individual psychotherapy services to my daughter, CHILD=S NAME, born DATE. I understand that the purpose of this therapy is to give CHILD, a place where it is safe to share and explore her feelings, including feelings about both her parents, without fear that this information will be reported to either parent, and/or used in court proceedings. I agree to allow this psychotherapy to be completely private.

I hereby forgo my rights to question Dr. _ regarding what occurs during psychotherapy sessions with CHILD, and forgo my right to review any and all psychotherapy records kept by Dr. _ regarding his contacts with CHILD, or myself. Furthermore, I agree I will not subpoena Dr. _ to testify at any court hearing or subpoena his records regarding his treatment of CHILD.

I agree that I will not question CHILD about the content of her psychotherapy sessions with Dr. _. CHILD is free, at her own discretion, to keep the content of the therapy private or to share selected information with either of her parents. However, I will exert no pressure on CHILD to share information.

Upon my request, Dr. _ will provide me with very general information regarding CHILD=s treatment, including dates of service, and a general statement as to whether he feels that the psychotherapy is useful and productive for CHILD. Any information so provided will be given equally to both CHILD=s parents.

If child has issues regarding either parent, Dr. _ may help CHILD communicate directly

with her parents by writing a letter or by meeting with one or both parents with Dr. _ present.

Dr. _ will specifically NOT become involved in the legal process of a custody/visitation dispute regarding CHILD. Should CHILD provide information to Dr. _ relevant to custody/visitation issues, he may encourage CHILD, to disclose that information directly to appropriate parties, for example, to Dr. XXXX who is the parent coordinator.

I understand that there are limits regarding CHILD=s confidentiality. Dr. _ must comply with Massachusetts laws regarding reporting of suspected abuse or neglect. Also, if Dr. _ receives information from CHILD, which leads him to believe that she is of immediate danger to kill or seriously harm herself or another, he must takes appropriate steps to warn the necessary parties. Dr. _ conducts no electronic transactions involving patient data and is not subject to the Health Insurance Portability and Accountability Act (HIPAA).

Termination of Dr. _'s treatment with CHILD shall take place when Dr. _ believes that such treatment is no longer of benefit to CHILD, or if both CHILD=s parents agree to end the treatment. If CHILD=s parents disagree regarding ending treatment, they will bring the matter to Dr. _ for review, and, if necessary, obtain a ruling from the parent-coordinator, Dr. XXXX. Once it is decided that treatment will end, Dr. _ will have (at his discretion) up to three additional sessions with CHILD to appropriately terminate treatment.

Therapy sessions with CHILD will be of 45 to 50 minutes duration, and will occur weekly or at a frequency specified by Dr. _. Dr. _ is billing at a rate of $---- per therapy session. Responsibility for payment for Dr. _'s services shall be as specified by court. I agree to pay in advance for any time I spend individually in consultation with Dr. _ regarding CHILD.

Payment in full for CHILD=s therapy sessions will be made at the time of each session. Dr. _ agrees to provide receipts, and to complete billing forms required for insurance reimbursement, however, he will not provide detailed treatment information to the insurance company, since such detailed information might become available to CHILD=s parents. I understand that my insurance may refuse to pay for services because Dr. _ will not provide them with detailed information for their utilization review process. If Dr. _ receives reimbursement directly from my insurance, that money will be returned to me.

There will be a charge of $--- for any session cancelled without 24 hours notice. This charge is payable by the parent who was responsible for the cancellation. Dr. _ will also charge at the hourly rate of $--- per hour for any telephone consultation longer than 5 minutes. These charges are not reimbursable by insurance.

Dr. _ has given me a copy of this contract and requested that I review it with an attorney

prior to signing it. Each parent must sign a copy of the contract for it to go into effect.

[If an older child has felt that a previous therapist has been under the sway of one parent or has revealed confidential info to a parent, I may add a paragraph as to how I handle communication with that previous therapist, for example, waiting a period of time before gathering info from that therapist.]

[If the child feels that a previous therapist has been unduly influenced by one parent, I may add a paragraph limiting the ways in which parents communicate with me, for example, only in writing and only with a copy to the other parent]

[If step parents exist I may have them also sign this contract, slightly modified to acknowledge their role.]

Signature: _____ Date: _____

Please Print:
Name _____

Address _____

City, State, Zip _____