PSYCHOLOGICAL SOLUTIONS, LLC sm

Encouraging Health • Exploring Answers sm

1050 W. Elm, Suite 250, P.O. Box 288 • Hermiston, OR 97838 • (541) 289-7777
Douglas Marlow, Ph.D. • Clinical Psychologist • Oregon License Number: 1335

Agreement for Psychotherapy or Assessment with a Minor

I, _____, the parent/legal guardian of the minor, _____, give my permission for this minor to receive psychological evaluation and/or treatment:

1. _____
2. _____
3. _____

This is for the purpose(s) of: (check all that apply)

1. Academic Improvement _____
2. Social Improvement _____
3. Family Improvement _____
4. Other (please specify) _____

These services are to be provided by the therapist named above. The fees for these services will be $120.00 per hour of service or as specified by contract or agreement.

This therapist's office policies concerning missed appointments have been explained to me. I have been told about the risks and benefits of receiving these services and the risks and benefits of *not* receiving these services, for both this minor and his or her family.

I agree that this professional may also interview, assess, or treat these other persons:

1. _____
2. _____

Because of the laws of this state and the guidelines of the therapist's profession, the following rules concerning privacy will be used: Information that is shared in treatment is held in the strictest confidence possible under law. Dr. Marlow will follow HIPPA and Oregon law and will not release information disclosed to him in the course of treatment or evaluation, with the following exceptions.

1. Information that a client poses a “clear and imminent” danger to himself/herself or others.
2. Information about treatment of minor children may in some cases be disclosed to their parents.
3. Information that would assist others treatment for a medical emergency.
4. A judge may order my testimony if he/she determines that the issues demand it.
5. Information necessary for an insurance company to process the insurance claim.
6. “Unless otherwise ordered by the court, an order of sole custody to one parent shall not deprive the other parent of the following authority:” to consult with a care provider and to inspect records, and to authorize emergency care if the custodial parent is, for practical purposes unavailable. ORS 107.154(3,4).

My signature below means that I understand and agree with all of the points above.

_____ _____
Signature of parent/guardian Date

I, the therapist, have discussed the issues above with the minor client's parent or guardian. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent to the minor client's treatment.

_____ _____
Signature of therapist Date

☐ Copy accepted by parent/guardian ☐ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.