Office

of

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Child/Adolescent

Informed Consent Disclosure Statement Of Services and Responsibility

Preamble

Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. Direct Quotation: American Psychologist: Journal of the American Psychological Association, December 2002. (2002 Ethics Code: Defining Moments of a Generation)

Psychological Services

No person in Florida may call himself or herself a psychologist unless that person is licensed by the State of Florida, Board of Health, Division of Medical Quality Assurance. This signed original Informed Consent Statement will become part of your psychological records so that the Board has some assurance that you are aware of the following important information. You will be given a copy for your own records.

Service provision in psychology is not easily described in general statements. It varies depending on the personalities of the psychologist (i.e., service provider, clinician, practitioner) and client (service user); thus, the therapeutic alliance with commitment. There are many different methods I may use to assist you as you deal with problems, conflicts, or difficulties that you hope to address. As a practitioner, overall, I follow the Behavioral/Science Model (i.e., research based) with a multi-model approach to establish our therapeutic alliance in therapeutic counseling.

Therapeutic counseling appears to help the service user (i.e., your child): reduce the symptoms which seem to be impairing life choices, begin to understand the variable dynamics of his/her present life, sense a overall fading of pain, perceive better behaviors replacing the less functional ones, realize more freedom of preferred options, and develop a clarity of the revising current living patterns. Typically, therapeutic treatment is not concluded until the cultural roots of one's misery have been explored and extirpated.

Although no guarantees or "magical cures" are extended, therapeutic counseling can have benefits (i.e., better relationships, solutions to specific problems, and significant reductions in feelings of distress), risks (i.e., experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness), but cannot resolve every single problem in one's life successfully. However, gains in communicating with confidence inside self (i.e., internal, emotions, decisions, options of choice), with others (i.e., external, levels of relationship), and life events (i.e., external, pleasant, unpleasant) frequently are spin-offs of developing emotional resiliency.

Specifically, my mission is to help people (e.g., your child/adolescent) learn to feel better, develop strength of inner self, and to build lifetime resiliency. Most people even children or adolescents seek balance for better health, less disease, greater inner peace, and a fuller sense of meaning, direction, and satisfaction in their lives every day. Scientific investigation of this neglected aspect of human nature may lead to important new clues for helping children/adolescents live together with better health, richer positive experiences, and greater meaning with satisfaction in life. Learning parallels of behavior and relationship with self and others could be facets in our work with your child/adolescent. At the end of your minor youth's therapeutic counseling treatment, I will prepare a written statement for termination.

Our first few sessions will involve an evaluation of your minor youth's present functioning and emotional influences from a historical glance. By the end of the initial evaluation, I will be able to offer you some first impressions of our work inclusions and a treatment plan to follow, if you decide to continue with therapeutic counseling. You can evaluate this information along with your own opinions of whether you feel comfortable in your minor young person's working with me. Therapeutic counseling involves a large commitment of time, money, and energy. Therefore it would benefit you to evaluate carefully the service provider that you select. If you have questions about my procedures, we will so discuss upon your request.

Meeting or Session Schedule – In Office or Telephone

I typically conduct a brief evaluation that will last two sessions. During this time, we can both decide if I am the best person to provide service addressing your child or adolescent's concerns. When the therapeutic counseling is begun, typically in the office, I will usually schedule one or two appointment session(s) (i.e., one session hour is 45 to 50 minutes in duration) per week at a preferred time(s) for you. The commitment requires consistency in attendance by the service provider and the service user. To avoid payment for missed appointment, please courtesy cancel at least 24 hours in advance of scheduled appointment. This policy helps me better serve new clients who may be waiting several weeks for their first appointment. Should a schedule conflict arise for you, I will try to reschedule the appointment for you.

Although in-office appointments are preferred, my private practice is a far-reaching international practice and I use consultation by telephone as a common and reliable technique of case management. Also, at times local service users or parents prefer to engage in telephone sessions during a crisis or time of conflict with an issue.

Professional Fee For Service

Overall my hourly fee is $225 for evaluation and $200 for therapeutic counseling. Therapeutic counseling by telephone is assessed in minute increments starting at your scheduled time. Telephone therapeutic counseling is billed by the minute (i.e., no charge for voice messages or calls of less duration than 5 minutes). In addition to telephone and in-office appointments, I charge specific amounts for other professional services. The fee schedule is listed below:

Fee Schedule

Service	Fee
Office Counseling:	$200 per hour (45-50 minutes)
Telephone Counseling:	$200 per hour (45-50 minutes)
Office Consultation:	$200 per hour (45-50 minutes)
Telephone/Internet/Facsimile Consultation:	$200 per hour (45-50 minutes)
Consultation/Counseling on Site:	$300 per hour (45-50 minutes)
Assessment:	$225per hour (45-50 minutes)
Record Review:	$200per hour (45-50 minutes)
Progress Session Summary:	$225per hour (45-50 minutes)
Court/Legal Related Consultation (hour/fraction):	$800 per hour (45-50 minutes)

Fees are collected at time of service unless you prefer to pay a retainer for the professional services to bill against. A fee of $25, in addition to the bank fee, will be charged on a returned check.

Comprehensive assessment can be billed by the test or test battery if more economical for the service user. Each service user is charged based on the fee schedule for service in practice at their time of entry. For example, if you begin therapeutic counseling under the above fee schedule, you will remain on this schedule regardless of my fee elevations reflecting costs of operation over time.

Each current service user will receive a copy of their ledger at the conclusion of each month. In addition, typically, I include a copy of a current, relevant research article for educational purposes. If the service user requests research in a specific area, I will attempt to so provide. In my opinion, mental health education supported by research is beneficial for almost everyone.

Because I do not file insurance, some service users prefer to pay for their psychological service and then file the fee receipt or ledger with their insurance company. Should the service user prefer this method, due to the privacy-confidentiality, I request that the service user sign an insurance release. You are aware that most insurance companies require you to authorize me to provide them with clinical diagnostic impressions. Sometimes I am required to provide additional clinical information such as treatment plans, summaries, or copies of the entire record (i.e., in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with the data once it is in their hands. In some cases, they may share the information with a national medical information databank. I will communicate with you should questions arise.

Because of the difficulty, time, and schedule disruption for other service users, related to legal involvement, I charge $700 per hour or fraction of the hour for my preparation, travel, and attendance at any legal proceeding on behalf of the service user. Alternately, the service user is responsible for paying my attorney fee should a legal altercation occur related to his/her case. In addition, depending upon the case, a minimum retainer or $7000 is required.

Contacting Me

I am often not immediately available by telephone (239-404-9396). When I am unavailable, my telephones are answered by voice mail, which I monitor frequently. When you record a message, it is helpful for your message to include you name, telephone number(s) where and when you may be reached, information related to your concerns or reporting, and possible times that I could speak with you. I will make every effort to return your call on the same day that you call, or within 24 hours, with the possible exception of weekends, holidays, and if I am out of town. Prompt communication is important to me and thus to our therapeutic counseling alliance.

In an emergency, if you are unable to reach me and sense that your difficulty cannot wait for me to return your call, contact your family physician or the nearest emergency room. Although seldom will I be unavailable for an extended time; however, should the situation happen you would be informed. My associate, Dr. Margaret Seagraves will have your release of file, and I encourage you to call and work with her at (239-596-4474) until my return.

Professional Records

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Service users will be charged an appropriate fee (e.g., list appears previously) for any professional time spent in responding to information requests.

Minors and Legally Incapacitated Individuals

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your or your child’s treatment records. Unless I sense that there is a high risk that you will seriously harm yourself or someone else, we (i.e., you and I) will provide them with general information about our work together in an ongoing format.

Service providers owe a duty of confidentiality to minor and legally incapacitated service users. This does not mean that the service provider may not impart the clinician’s own evaluation, assessment, analysis, diagnosis, or recommendations regarding the minor or legally incapacitated individual to the service user’s guardian or to any court of law.

Confidentiality and Privileged Communication

One of the primary obligations of psychologists is to respect the confidentiality of information entrusted to them by service users. Psychologists may disclose that information only with written consent of the service user's legal guardian or parent. The only exception to this general rule occurs in those situations when nondisclosure on the part of the service provider would violate the law. If there are limits to the maintenance of confidentiality, the service provider will inform the service user of those limitations.

As with most laws within our country and the State of Florida there are limitations. You will find below the limitations of this confidentiality as determined by Florida Psychological Services Act (490.0147) and Florida Statutes (415.504) and (415.103).

Florida Statute 490.0147 requires psychological service providers to breach confidentiality if it is determined that a service user presents a danger of harm to him/herself or others. If the patient presents an imminent danger to someone else, then that person must be notified according to Florida Statutes "Duty to Warn." If the service user presents a danger to him/self/herself, then appropriate therapeutic intervention is mandated, which may include hospitalization.

Florida Statute 415.504 requires the mandatory reporting of any knowledge of child abuse or neglect. This information must be reported. It is the policy of this office to notify the service user prior to reporting such information. This prior notification if a courtesy I provide to the service user and in no way will inhibit or delay the report of suspected abuse and neglect.

Florida Statute 415.103 requires the mandatory reporting of any knowledge of abuse, neglect, or the exploitation of the aged or disabled adults. This information must be reported. Again, it is the policy of this office to notify the service user prior to the reporting of such information. This prior notification is a courtesy I provide to the service user and in no way will inhibit or delay the report of suspected abuse and neglect.

A service user involved in litigation is potentially subject to certain exceptions to the right to privileged communication, such as, when the communications issues are (1) in proceedings to compel hospitalization of the client for mental illness; (2) made in the course of a court-ordered examination of the mental or emotional condition of the service used; or (3) relevant to an issue of the mental or emotional condition of the client in any proceeding in which he or she relies upon the condition as an element of his or her claim or defense.

In general, the privacy of all communications between a service user and service provider is protected by law. I can only release information about our therapeutic counseling to others with your written permission (i.e., release of specificity from this office). For example, you and I may decide that it would be helpful to you for me to talk with your child's medical physician.

There are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your minor youth's treatment. Although extremely seldom, in some proceedings, typically, involving child/adolescent custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm even if I have to reveal some information about a service user's treatment. For example, if I believe that a child/adolescent is being abused, I may be required to file a report with the appropriate state agency. If I believe that a service user is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for this service user. If the service user threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations rarely occur. Should a similar situation occur, I will make every effort to discuss it with you before taking action.

I may find it helpful to consult with other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my service user. The consultant is also legally bound to keep the information confidential. Should this situation occur, I will inform you. Alternately, should you prefer that I consult with other professionals, I will comply upon your signature on the release of information from this office.

In this office, the clerical staff will have access to your records. The clerical staff members work under this office policy, are legally bound, and have been trained with ongoing supervision to guard your confidentiality.

Service Provider - Service User Relationship

It is never appropriate for a service provider to engage in any relationship (e.g., social) other than service provider - service user relationship with any service user or former service user. For example, a service provider may not hire a service user or former service user as an employee.

Problem Resolution

If you have concerns about a service provider who is working with your family, you may first discuss the issues with your service provider. If this is not satisfactory and you need further help, you can discuss your concerns with another psychologist or contact (1) the Florida Psychological Association, (2) the American Psychological Association, or (3) the Florida division of Medical Quality Assurance.

MINOR CHILD/ADOLESCENT CONSENT - REGISTRATION FORM

I, ______________________________________, give consent for Dr. Walters to provide psychological services (i.e., evaluation, counseling) with my minor child/adolescent, ____________________________, date of birth ____________.

Consenting Authority's Signature Legal Relationship

Witnessed by me this _____day of ________________ 2003. Name/Title ______________________

CHILD/ADOLESCENT REGISTRATION FORM

Child's Name ____ Date _____________
(Please Print) Last First Middle

Referred By ___________________________ Address _________________________________

Custodial Parent/Guardian Name(s) ____

Custodial Parent/Guardian Address

____
Number Street City State Zip

Telephone Numbers ____
Home Cell Business(s)

Youth's Age ___ Date of Birth ________ Grade ____ Social Security Number __________________

Date of Last Medical Evaluation _________ List Current Health Problems ______________________

List MEDICATIONS child/adolescent is now taking ____

What has child/adolescent been hospitalized for in the past? ____

What illness has the child/adolescent had during life (e.g., asthma, diabetes, seizures)? ______________ Has he/she received emotional, psychological, or psychiatric counseling? If so, describe including service provider

____

What medical, emotional, psychological, or psychiatric diagnoses have been made in the minor youth's family?

What is the parents' <u>marital status and date</u> (i.e., single, married, separated, divorced, remarried, widowed)?

Briefly describe/explain the presenting problem(s) or reasons you arranged time in this office.

Briefly explain what intervention has been tried to resolve or reduce the problem.

List the strengths of your child/adolescent's strengths.

Presenting Problems

Please check (√) the following that apply to your child/adolescent. Does your child/adolescent have problems with **thoughts** of:

[ ] Not being good enough
[ ] Not being cared about
[ ] Not belonging/fitting in
[ ] Not being understood
[ ] Being rejected
[ ] Being abandoned
[ ] Being a failure
[ ] Being unattractive
[ ] Being overweight
[ ] Hopelessness
[ ] Not being real
[ ] Not knowing identity
[ ] Hearing voices or sounds inside head
[ ] Hearing voices or sounds around that others can't or don't hear
[ ] Seeing things or people that others can't or don't see
[ ] Having special powers
[ ] Being superior or privileged
[ ] Being in danger
[ ] Being followed or spied on
[ ] Revenge/getting even
[ ] Racing ideas
[ ] Being bad or evil
[ ] Flashbacks of past trauma
[ ] Hurting self
[ ] Killing self
[ ] Hurting others
[ ] Killing others
[ ] Sexual preoccupation
[ ] Excessive religiosity
[ ] Nightmares
[ ] Medical condition
[ ] Impending death/doom

Please check (√) the following that apply to your minor youth. Does your child/adolescent have problems with **feelings** of:

[ ] Guilt
[ ] Apathy/indifference
[ ] Boredom
[ ] Intense loneliness
[ ] Intense sadness
[ ] Helplessness
[ ] Depression
[ ] Irritability
[ ] Intense frustration
[ ] Anger
[ ] Hate
[ ] Rage
[ ] Tension
[ ] Being under pressure
[ ] Being out of control
[ ] Anxiety/apprehension
[ ] Specific fears/phobias
[ ] Intense excitement
[ ] Obsessive infatuation
[ ] Mistrust/suspiciousness

Please check (√) the following that apply to your minor youth. Does your child/adolescent have problems with the following **behaviors**:

[ ] Aggression/fighting
[ ] Stealing
[ ] Vandalism
[ ] Fire setting
[ ] Using drugs and/or alcohol
[ ] Gambling
[ ] Sex or sex related
[ ] Child abuse and/or neglect
[ ] Eating
[ ] Sleeping
[ ] Smoking
[ ] Bed wetting
[ ] Performing in public
[ ] Compulsions
[ ] Irresponsibility
[ ] Inefficiency
[ ] Making decisions
[ ] Avoidance
[ ] Procrastinating
[ ] Forgetting
[ ] Arguing
[ ] Lying
[ ] Temper
[ ] Impulsiveness
[ ] Running away
[ ] Being oppositional/rebellious
[ ] Masochistic acts
[ ] Self-mutilation/injuring self
[ ] Suicidal
[ ] Bossing or controlling others
[ ] Sadistic acts
[ ] Homicidal acts
[ ] Attention/concentration
[ ] Achievement
[ ] Self-defeating acts
[ ] Being too dependent
[ ] Perfectionism
[ ] Socializing with others
[ ] Helping others too much
[ ] Taking the blame
[ ] Being taken advantage of

Other:

[ ] Relationship
[ ] Marital
[ ] Family
[ ] Parenting
[ ] Job related
[ ] Financial
[ ] School/education related
[ ] Physical/medical related
[ ] Religion or spiritual

Father's Name ______________________________ Social Security Number __________

Is this father the child/adolescent's biological father, stepfather, adoptive father, foster father, or guardian? _____

Is the father presently living in the home with the child/adolescent? ___ If not, visitation arrangement? ________

If Applicable, Joint/Individual Custody ____________________ Primary Residence (yes/no) ______

Address ____
Number Street City State Zip

Telephone Numbers ____
Home Cell Business(s)

Education/Training ________________ Employer __________________ Occupation ___________

Spouse/Significant Other Name _________________ Telephone __________ Occupation _______

Mother's Name ______________________________ Social Security Number __________

Is this mother the minor youth's biological mother, stepmother, adoptive mother, foster mother, or guardian?

Is the mother presently living in the home with the child/adolescent? ___ If not, visitation arrangement? ______

If Applicable, Joint/Individual Custody ____________________ Primary Residence (yes/no) ______

Address ____
Number Street City State Zip

Telephone Numbers ____
Home Cell Business(s)

Education/Training ________________ Employer __________________ Occupation ___________

Spouse/Significant Other Name ________________ Telephone _________ Occupation ______

List the members of the minor youth's family and all others in the child/adolescent's home(s)

Names	Age/Birthdate	Relationship	Occupation

List the schools your child/adolescent has attended.

School	Grade	City, State

Has your child/adolescent passed each grade?____ If not, list the grade level(s) retained. ________

Presently what grade(s) is your child/adolescent receiving in each subject? _______________________________

Is you child in special classes in school? ____

Emergency/ Next of Kin Contact Name ________________ Telephones ______________________

Address ____ Relationship ______________

Notes:

Thank You

Thank you for selecting me as your service provider. I hope that my work in assessment, therapeutic counseling, and/or consultation will be helpful. If you have any concerns or questions, please do not hesitate to talk with me.

Your signature below indicates that you have read, understand, and will abide by the information on this Informed Consent Disclosure Statement, covering protocol, fee structure, and type of intervention offered by Dr. Phyllis Walters during our professional relationship.

Service User:

____
Signature

Print Name: __________________________________

Date: __________________

Witness:

____
Signature

Print Name: _______________________

Date: ________________

Service User's Legal Guardian:

____
Signature

Print Name: __________________________________

Relationship:___________________________________

Date: __________________

Biographical Introduction: Phyllis Walters, Ph.D.

Phyllis Walters, Ph.D. is licensed in Florida and nationally certified as a school psychologist, who specializes in assessment, intervention, and consultation. She provides service with individuals, couples, and families in her private practice. Specifically, the service addresses issues with children, adolescents, and adults who present signs of: anxiety impulses, depression despair, obsessive compulsive behaviors, learning difficulties, relationship issues, life stage transitions, divorce challenges, blended family integration, or related problems.

Dr. Walters earned a Doctor of Philosophy Degree (Ph.D.) from The University of Northern Colorado and her Master of Science degree in School Psychology from the University of Alabama. During her graduate education at the University of Northern Colorado, Dr. Walters completed a variety of training experiences including working in the University Mental Health Clinic where she provided counseling services to families, couples, individuals, and children. Dr. Walters is trained in a variety of therapies including hypnosis, individual therapy, family therapy and play therapy. She completed practicum experiences at the J.F.K. Center for Developmental Disabilities, Denver Children's Hospital, and The University of Northern Colorado's Neuropsychology and Family Therapy Clinic. Dr. Walters completed a dissertation entitled *Traumatic Brain Injury Self Report: Identifying the Relationship between Personality Style and Risk Taking Behavior.*

Dr. Walters has worked extensively with school and college aged students in both the private and public sector helping them to achieve their personal best. She strives to help people learn to feel better, develop their strength of inner self, and to build lifetime resiliency.
Dr. Walters was employed by The University of Alabama as a Career Counselor and Learning Disabilities Specialist. In this role she provided counseling and psychoeducational assessments to a variety of students with learning difficulties including ADHD, Depression, Anxiety, and learning disabilities. Dr. Walters has worked in a number of school districts across the country as a school psychologist providing assessment, counseling, and consultation to students, staff, and parents. Currently Dr. Walters runs a private practice in Bonita Springs and also is employed by Collier County Public Schools as a School Psychologist.

To provide services for individuals in Naples, Florida, and Bonita Springs, Florida, Dr. Walters opened the private practice in 2002.