



**Jamie Chin, M.A., MFTI**

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## INFORMED CONSENT AGREEMENT

Welcome to the practice of Jamie Chin. Congratulations in taking the first step in working toward positive change. I look forward to assisting you in pursuing your goals. It is very important to me that your experience here be both positive and helpful. If at any time you have questions or concerns about your treatment, please discuss them with me. I am committed to helping you and your family.

It is important for you to know that therapy involves both **benefits and risks**. Risks include the possibility of experiencing uncomfortable levels of feelings such as sadness, anger, and helplessness. Psychotherapy often requires recalling experiences, some of which may be unpleasant. Therapy also involves making changes that can feel threatening to you and those close to you. Psychotherapy has been shown to have benefits to those who undertake it. It often leads to a reduction of feelings of distress, the resolution of specific problems, better relationships, and feelings of well-being. Due to the varying nature of severity in issues and individuality of the client, I am unable to predict the length of therapy or guarantee a specific outcome or result.

As part of the therapy process, it is important for you to understand **your rights to confidentiality**. I am legally bound to keep confidential the information shared during the therapy session. There are important exceptions to the confidentiality of the therapy relationship. Therapists are required or permitted by law and professional ethical codes to reveal certain information under the following circumstances:

- if the therapist believes you are at risk of hurting/harming yourself or another person.
- if the therapist is concerned about child abuse and/or neglect.
- if the therapist is concerned about the abuse/neglect of elderly or dependent adults.
- if a court of law orders the release of specific information.

### **Therapy with Children**

Psychotherapy with children can involve a variety of different activities, which vary from client to client. In general, I will work with you and your child to assess your child's problems and then provide therapeutic services designed to resolve or reduce the problems. This may involve individual work with your child, discussions with you about ways to help your child outside of therapy, and/or family sessions. With children and adolescents, therapy often includes play and art activities used as a means of understanding and communicating with the client.

It is important for your child or adolescent to be able to explore his/her thoughts and feelings in therapy. In order to do this, your child or adolescent needs to be assured of his/her own right to privacy. I will maintain your child's confidentiality within the legal exceptions noted above. This means that I will not share the specifics with you of what your child or adolescent says in therapy. However, I will respect your right, as the parent or legal guardian of the child, to know what is happening with your child in therapy. I will let you know the following about your child's therapy: 1) general issues that are being worked on, 2) ways that you can help your child and, 3) situations that I deem unsafe for your child and that require your intervention to help keep them safe.

### **Authorization to Treat a Minor**

Please enter the name and age of each child who is to receive therapy serviced in the space below. By signing this agreement, you are authorizing treatment for those minors. You are also stating that you have the legal right to consent for their treatment. The child/children who will be seen are:

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

**Appointment Scheduling and Cancellation Policies:**

The standard fee for service is \$90.00 per session. Appointments are arranged so that we share a consistent, ongoing weekly or biweekly scheduled time together. Sessions are scheduled for 50 minutes (45 minutes for children). If appointments must be cancelled, 24 hours prior notice is expected to avoid being charged for that hour. You will also be charged if you "no show" for your scheduled time.

*A sliding fee scale is available for those who qualify. Please speak with me if the above fee poses financial difficulty, so I may offer possible options for you.*

Your fee is \$\_\_\_\_\_ per session. Payment is due at the beginning of session.

**Please initial to indicate your agreement with fees, scheduling, and cancellation policies \_\_\_\_\_**

**For clients wanting to use insurance:**

As a Marriage, Family Therapist Intern, I am unable to accept insurance. I do, however, accept Victim Witness Compensation. Please inquire if this pertains to you.

**Ending Therapy:**

The process of ending therapy can be a significant part of healing. If you intend to end therapy for yourself or your child, please discuss this with me in advance so that an appropriate closure process can be planned.

**Counseling services are available only during scheduled office hours.**

In the event of a crisis, you may utilize Sacramento County Mental Health Crisis Line at (916) 875-1000.

**I have read the above information. By signing below I am stating that I understand and agree to the contents of this agreement.**

\_\_\_\_\_  
Adult Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Minor Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Adult Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Minor Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Adult Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor

\_\_\_\_\_  
Date