

## CHILD INFORMATION FORM

CHILD'S NAME: \_\_\_\_\_

### MEDICAL HISTORY:

- Medical Problems during pregnancy
- Maternal drug or alcohol use during pregnancy
- Premature birth
- Complications during birth
- Stayed in neonatal ICU
- Health problems as newborn or toddler
- Frequent ear infections
- Asthma or allergies
- Head injuries/concussions/seizures/high fevers
- Serious accidents/hospitalizations
- Surgeries
- Problems with eating or sleeping

Other: \_\_\_\_\_

### DEVELOPMENTAL HISTORY

Problems with:

- Early milestones?
- Reading or letter identification
- Physical coordination
- Responding to discipline or behavior management
- Anger/temper tantrums
- Fears
- Sexual Play

Other: \_\_\_\_\_

### CURRENT CONCERNS ABOUT YOUR CHILD (please circle those that apply)

Behavior at home/school      Mood    Eating    Sleeping

Suicidal Thoughts      Academic performance/grades    Anger/Irritability

Difficulty paying attention    Peer relationships    Health

Drugs/Alcohol      Sexual behavior      Frequent worries/shyness

Sensitive to touch, sound, motion Receiving special services (OT, PT, Speech)

Comments: \_\_\_\_\_

### CHILD'S STRENGTHS OR ABILITIES

Academic grades                      Sports                      Creative (art or music, etc)  
Group involvement (club, organizations)                      Religious Involvement  
Sense of Humor                      Care for Others                      Other \_\_\_\_\_

Explanation: \_\_\_\_\_  
\_\_\_\_\_

### CHILD'S SOCIAL RELATIONSHIPS

Does your child have a friend or friends outside the family? \_\_\_\_\_

Does his/her friends tend to be: \_\_\_older \_\_\_younger \_\_\_about the same age

How well does your child get along with others?  
\_\_\_\_\_

### FAMILY HISTORY

Has anyone in the family struggled with (treated or untreated):

- \_\_\_ Depression or Bipolar?
- \_\_\_ Anxiety?
- \_\_\_ Learning problems?
- \_\_\_ Attention problems?
- \_\_\_ Excessive alcohol or drug use?
- \_\_\_ Sexual abuse?
- \_\_\_ Physical Abuse?
- \_\_\_ Suicide attempts or completed suicide?

Do you have any other concerns about your child?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MALAIKA CLELLAND, MSW, LCSW, RPT-S**

CA License# LCS 21371

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949-547-2050/malaikaclelland@gmail.com

Hello,

Welcome to my practice. I am a Licensed Clinical Social Worker and Registered Play Therapist with a Master of Social Work degree from Loyola University Chicago. Since graduating in 1996 I have been working with a wide variety of children and families. I have had post graduate training and work experience in the area of children’s mental health including grief and trauma therapy, infant, toddler and early childhood mental health, divorce, attachment, crisis work, and family therapy.

This form requests information about your needs and informs you of my services and policies. Please take a few moments to complete this form. The questions on the following pages are designed to help me best meet your treatment needs. If the person seeking care is a child, the parent or guardian should complete this form. If you have any questions, I will be happy to answer them.

Child’s Name\_\_\_\_\_

Birthday\_\_\_\_\_ Age\_\_\_\_\_

Address\_\_\_\_\_

Home Phone#\_\_\_\_\_ Work/cell#\_\_\_\_\_

Email\_\_\_\_\_

Relationship Status/ Status of Parents if child: Single Married Domestic Partner Separated Divorced Widowed

School: \_\_\_\_\_

Primary Care Physician\_\_\_\_\_ Phone#\_\_\_\_\_

Religion/Spiritual Practices\_\_\_\_\_

Race/Culture\_\_\_\_\_

Emergency Contact\_\_\_\_\_ Phone#\_\_\_\_\_

Please list other persons living in your household and their relationship to you:

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If child does not live with both biological parents, where does other parent reside?

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

**Insurance Information:**

If you have PPO insurance you may be reimbursed by your insurance carrier for “out of network” coverage. I will bill your insurance for out of network on a superbill form. A Superbill shows what you paid for services and the insurance carrier will reimburse YOU at their out of network rate. Payment is expected at time of service.

Primary  
Carrier \_\_\_\_\_

Address \_\_\_\_\_

Insured \_\_\_\_\_

Insured Date of Birth \_\_\_\_\_

Payer/Health  
Plan \_\_\_\_\_

Member  
# \_\_\_\_\_ Policy/Group# \_\_\_\_\_

Client’s relationship to insured: \_\_\_\_\_self \_\_\_\_\_spouse \_\_\_\_\_Dependent

In order for me to submit a claim for payment for the services covered under your policy, I must have your authorization to release medical information to your insurance carrier. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the provider indicated on the claim.

**I understand I am financially responsible for any balance not covered by my insurance carrier.** A copy of my signature below is as valid as the original.

Dated \_\_\_\_\_

By \_\_\_\_\_

Patient or Other Authorized Person

Please describe your reason(s) for seeking treatment at this time. If there is a particular event that triggered your decision now, please list the event:

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What result(s) do you expect from treatment?

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Have you ever received mental health treatment before? If so, please list dates, provider name and the issues you sought treatment for:

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Please list any medications you are currently taking:

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Please indicate your major life stressors of the past 12 months:

\_\_\_ Serious Illness or Injury      \_\_\_ Death of a Close Friend or Family Member

\_\_\_ Gain of New Family Member    \_\_\_ Divorce/Separation

\_\_\_ Major Illness in Family      \_\_\_ Job Change    Other \_\_\_\_\_

**Treatment Philosophy:**

I approach treatment from a family systems approach and therefore believe in involving parents in the process of therapy for children. I also use play therapy, attachment theory and Cognitive Behavioral Therapy and often integrate these treatment theories to form a specific treatment plan. Treatment goals will be developed after a thorough assessment and we will evaluate these goals together periodically as treatment progresses. If you have any questions about how therapy works please don't hesitate to ask.

**GENERAL INFORMATION**

Malaika Clelland, LCSW, RPT offers professional counseling services to children, adolescents, families and individual adults. I utilize short-term and long-term therapy modalities. The following information is important for you as a client to know.

- I am an independent practitioner working part time hours. I will attempt to return phone calls and emails within 24 hours for non-emergencies.
- All personal information is confidential, including the fact that you are a client with me. I conform to federal and state laws regarding therapist/client confidentiality. No records of information will be shared with anyone without your expressed written permission to do so. Exceptions to this policy as I am mandated by law to report include the following:
  - 1) If you threaten grave bodily harm or death to another person or yourself
  - 2) If a court of law issues a legitimate subpoena
  - 3) If child physical abuse, sexual abuse or neglect is suspected with a minor
  - 4) If physical elder abuse is suspected with a person sixty-five (65) years or older

**PARENTAL CONSENT FOR TREATMENT OF A MINOR**

In accordance with State Law, AB657, I have been informed that my child(ren) has (have) been referred for counseling services offered by Malaika Clelland, LCSW.

I understand that my child(ren) may not receive these services without my written consent.

I hereby give my consent for \_\_\_\_\_  
to receive counseling from Malaika Clelland, LCSW.

\_\_\_\_\_  
Parent/Legal Guardian Date: \_\_\_\_\_

\_\_\_\_\_  
Parent/Legal Guardian Date \_\_\_\_\_

\_\_\_\_\_  
Witness Date \_\_\_\_\_

Exceptions to this policy, under law, include the following:

- 1) The minor must be at least 12 years of age, AND
- 2) The minor must be mature enough to participate intelligently in counseling.

If there are exceptions please document here:



Each therapy session is scheduled to last 55 minutes. You will not be charged for a session if you cancel your appointment at least 24 hours prior to the scheduled appointment time. **If you fail to keep an appointment or do not cancel within 24 hours of the scheduled appointment time, you will be charged a \$50 cancelation fee.**

You may call or email me and I will return your non-emergency message within 24 hours. If phone contact occurs frequently for lengthy periods of time, you may be charged for this time. If you are experiencing an emergency please call 911 or go to the emergency room.

It is customary to pay for services at the time of each session. Payment for services can be made with cash, check or credit card. Medical insurance billing is done as a courtesy if you are using in network or out of network insurance. **You are responsible for your account.** If you are using out of network insurance you will be responsible for paying at the time of service and your insurance company will reimburse you at their rate. Although I file insurance claims for you, **you carry the insurance coverage and payment for services is ultimately your responsibility.**

FEE SCHEDULE:

\$140.00 Per 55 minute session for Individual Therapy and/or Family Therapy

Any adjustments in fee, based on special circumstances, must be discussed in advance.

My fee for counseling services with Malaika Clelland, MSW, LCSW  
Will be \$\_\_\_\_\_ per clinical hour.

I/We, the undersigned, have read this letter of financial agreement and do hereby agree to its terms and conditions.

\_\_\_\_\_  
Client's Signature Date

\_\_\_\_\_  
Client's Signature Date

\_\_\_\_\_  
Therapist's Signature Date

I authorize the release of any medical information necessary to process this claim. I also request the payment of benefits to myself or to the party who accepts assignment.

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
Patient or Authorized Person's Signature

I authorize payment of medical benefits to the undersigned provider for services described herein.

Signed: \_\_\_\_\_ Date \_\_\_\_\_

**Malaika Clelland, LCSW, RPT-S**  
**Licensed Clinical Social Worker**  
**Registered Play Therapist – Supervisor**  
**LCS 21371**

**27001 La Paz Road suite 266A**  
**Mission Viejo, CA 92691**  
**Telephone: (949) 547-2050**

## **INFORMED CONSENT REGARDING OUT-PATIENT CHILD PSYCHOTHERAPY**

This Agreement has been created for the purpose of outlining the terms and conditions of services to be provided by Malaika Clelland, for the minor child(ren) \_\_\_\_\_ (herein “Client”) and is intended to provide [name of parent(s)/legal guardian(s)]

\_\_\_\_\_ with important information regarding the practices, policies and procedures of Malaika Clelland, (herein “Therapist”), and to clarify the terms of the professional therapeutic relationship between Therapist and Client. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

California law requires that parents or legal guardians be provided with information to allow them to make informed decisions about their child's participation in psychotherapy. This document provides information on risks and benefits of psychotherapy, medical concerns, assessment, the need for children and adolescents to have confidential psychotherapy, collateral contacts, treating children of separated or divorced families, professional records, confidentiality from third parties, evaluating the accuracy of children's disclosures and memory, implications of knowledge of children's disclosures and memory for psychotherapy and related legal issues, alternative treatments, diagnoses, treatment plan, length of treatment, psychotherapy fees, cancellations, and emergencies. Please read this information carefully, ask your child's therapist any questions you may have, and as these issues are understood, please initial in the places provided.

### **Risks and Benefits of Psychotherapy**

Most children receiving psychotherapy are experiencing psychological problems that cause internal distress and/or problems in their relationships. The goal of psychotherapy is reduction of such problems. Failure to obtain needed psychotherapy often results in an exacerbation of psychological problems. However, some children experience an exacerbation of problems or different problems in the course of psychotherapy.

These problems can include increases in anxiety, depression, sadness, sleep disturbances, eliminatory disorders, intrusive thoughts, flashbacks, self-destructive or angry impulses, behavior problems, social problems, academic problems, suicidality, and problems in family relationships. Hospital care or residential treatment may be required.

Children in psychotherapy benefit from having a strong support system, including family, friends, and a supportive school environment. For many children, cultural and religious affiliations are important. Expressive activities, such as play, art, writing, music, exercise, are also important for mental health of children. Other treatment modalities, such as family therapy, group therapy, 12-step groups, support groups, and medication, may be helpful. Your child's therapist will provide referrals to help develop a support system at your request.



In most cases, therapy eventually improves a child's sense of well-being and relationships. In some cases, children obtain little or no benefit from therapy, or become worse. It is not always possible to predict the outcome for an individual. Given this knowledge, the decisions to begin, continue, or terminate therapy for your child generally belongs to a child's parents. These decisions may be evaluated with one's therapist or independent consultation for a second opinion may be obtained at any time.

Initial here if this section has been read and understood \_\_\_\_\_

### **Medical Concerns**

Your child's psychotherapist is not a medical doctor and therefore cannot recognize or diagnose medical conditions. It is essential that you obtain a medical examination for your child to determine any medical origins of his or her psychological problems, e.g., neurological, genetic, and endocrinological abnormalities, allergies, glucose and insulin imbalances, food sensitivities, toxins, infectious disease, gastrointestinal disorders, medication side effects, etc. Not being a medical doctor, your child's psychotherapist cannot prescribe psychiatric medication, but will refer your child for psychiatric consultation if this appears to be indicated.

Initial here if this section has been read and understood \_\_\_\_\_

### **Assessment**

Psychotherapists must conduct both an initial and ongoing assessment of children to understand their psychological needs. It is essential that you cooperate with this assessment process by completing all forms and questionnaires provided to you and by meeting with your child's therapist, with or without your child present, as your child's therapist indicates. Please be completely open and honest with your child's therapist about all influences that may be affecting your child, even if doing so is painful or embarrassing. Therapists can only help children with problems to the extent that they are provided with the whole picture.

Initial here if this section has been read and understood \_\_\_\_\_

### **The Need for Children and Adolescents to have Confidential Psychotherapy**

As a parent or guardian of a child receiving psychotherapy, your child's psychotherapist will involve you in helping your child to the fullest extent possible. However, the content of your child's sessions must be confidential in order to enable your child to confide in his or her therapist and for therapy to be effective. Parents will be provided with general overview on how your child is progressing towards his or her treatment goals.

In treatment of adolescents, there are many issues that therapists have no opportunity to address unless adolescents trust that communication in therapy will not be shared with parents or guardians. These issues include use of cigarettes, alcohol, drugs, sexual concerns or behavior, involvement in gangs, cutting classes or truancy, school failure, unauthorized time with peers, and criminal activity. Your adolescent's therapist will work to help him or her behave in ways that are not self-destructive, that do not limit his or her options for the future, and that are considerate of others. If any such issues rise to the level of serious, imminent danger to self or to others, the appropriate authorities must be notified, and parents will be notified unless contraindicated.

Initial here if this section has been read and understood \_\_\_\_\_

## **Collateral Contact with Parents and Others**

Your contact with your child's psychotherapist is collateral, that is, auxiliary to your child's treatment for the purpose of assisting in your child's treatment. Your child's therapist is not treating you and has no therapeutic obligation to you. Therefore, your communication with your child's psychotherapist is not privileged or confidential. Your child's therapist will provide you with psychotherapy referrals if you request such referrals or if your therapist believes that therapy for you would better help you help your child.

Initial here if this section has been read and understood \_\_\_\_\_

## **Treating Children of Separated or Divorced Parents**

In families of separation and divorce, children's psychotherapists work to help them cope adaptively with the forces acting upon their lives. Treating children in these contexts is difficult because:

1. Both parents usually have different views of the forces acting upon the child and the child's needs.
2. Parents' views may be affected by their own psychological experiences, issues, and needs.
3. Both parents usually fear that the child's psychotherapist will side with the other parent.
4. Both parents usually fear that the child's psychotherapist will make custody or visitation recommendations that are not in the best interest of the child or parent.

For these reasons, your child's psychotherapist has instituted the following policies in treating children of separated or divorced parents who share legal custody:

1. Both parents must consent to treatment, ideally before the first session with the child, or shortly thereafter, or therapy must be ordered by a family or guardianship court, or by the child's attorney or guardian ad litem.
2. Both parents will be offered "equal time" in face-to-face or phone contacts as much as realistically possible, unless this is contraindicated, such as cases in which the therapist judges that contact with one or both parents might negatively affect the child (e.g., if there is a concern related to parental abuse or threats to the child).
3. Your child's therapist will not communicate with attorneys for either parent or guardian.
4. Any information provided by one parent may be shared with the other parent by the child's therapist.
5. Both parents must agree to not subpoena the child's therapist or to subpoena the child's therapy records.
6. Your child's psychotherapist will not provide custody or visitation recommendations to the court, mediator, or psychologist conducting a custody evaluation. If the child has a court representative (attorney, guardian ad litem, or other advocate), or if requested by both parents, your child's therapist may discuss observations about the child with the court representative. Your therapist also must divulge information if ordered by the court.

These policies may not apply when a parent resides out of the area or is incarcerated, when parent-child

contact is limited by a court (Juvenile, Family, or Guardianship) or court representative (e.g., Children's Services Bureau social worker), when there is substantial evidence that a parent has abused, endangered, neglected, or abducted a child, when the child has been exposed to domestic violence, when communication with a parent might physically or psychologically harm a child or damage the therapeutic relationship, or when a parent fails to respond to the therapist's attempts to establish contact with that parent.

Initial here if this section has been read and understood \_\_\_\_\_

## **Professional Records**

Psychotherapy laws and ethics require that California licensed psychotherapists keep treatment records. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. Your child and you are entitled to receive a copy of these records unless your therapist believes that viewing them would be emotionally damaging to you or your child, in which case your therapist will review them together with your child or with you, or will send them to a mental health professional of your choice, to allow you or your child to discuss the contents. Parents/guardians will be charged copying costs plus \$2.00 per minute for professional time spent responding to information requests.

Initial here if this section has been read and understood \_\_\_\_\_

## **Confidentiality**

Psychotherapy is confidential from parties other than parents with important exceptions:

1. Psychotherapists may release information to designated parties with written authorization from clients, parents, or legal guardians.
2. Psychotherapists are required to release information obtained from children or collateral sources (other individuals involved in a child's psychotherapy, such as parents, guardians, and siblings), to appropriate authorities to the extent to which such disclosure may help to avert danger to a psychotherapy client or to others, e.g. imminent risk of suicide or violence to others, destruction of property that could endanger others, and grave disability (inability to care for one's basic needs (food, shelter, clothing) even if provided to them). In case of serious threat of violence, therapists must also attempt to warn intended victims.
3. Psychotherapists are required to report suspected past or present abuse of children (including physical, sexual, or emotional abuse, or neglect), dependent adults, and elders.
4. If you choose to seek reimbursement from your insurance company for your child's psychotherapy, information, including psychological diagnoses, and in many cases, explanations of symptoms and treatment plans, must be provided to the third party. If you are seeking reimbursement from your health insurance, your therapist will provide you with a copy of a "superbill" at the end of the month that you can submit to your insurance company or as a courtesy will send the bill for you electronically.
5. If children participate in psychotherapy in compliance with a court order, psychotherapists are required to release information to the relevant court, social service, or probation departments.
6. Your child's psychotherapist and psychotherapy records may be subpoenaed in a variety of legal actions. I will attempt to quickly notify you of such requests. In some situations, subpoenas for

information or therapist testimony can be quashed, preserving confidentiality. In other cases, a judge may order therapist testimony or that the record be released, in part, or in full, including all information provided by collateral sources, including parents. In legal proceedings that introduce a child's psychological condition or mental capacity, or a parent's parenting capacity, the court often requires psychotherapists to testify and turn over treatment records. When children or parents initiate legal proceedings that place at issue any aspect of a child's psychotherapy, and in lawsuits that claim psychological damages by any party, psychotherapists are often court-ordered to release the full psychotherapy record to the involved parties and court. Notify your therapist of legal actions as soon as possible to discuss potential impacts on treatment and confidentiality.

7. Psychotherapists often consult with other professionals on cases, and teach or write about the psychotherapy process, but disguise identifying information when doing so. Please indicate to your child's therapist if you wish to place restrictions on consultation, teaching, or writing related to your child's case.

8. Your child's psychotherapist reserves the right to release financial information to a collection agency, attorney, or small claims court, if you are delinquent in paying your child's psychotherapy bill.

9. Cell phone and e-mail communication can be intercepted by third parties, thereby limiting your child's privacy. Such communication should be used with this knowledge in mind and should generally be reserved for time-sensitive matters. Psychotherapists are required to make a record of each client contact.

10. Your psychotherapist may be required by the government to disclose information concerning clients who are in the Armed Forces or for National and Homeland Security purposes without notifying you.

Initial here if this section has been read and understood \_\_\_\_\_

### **Alternative Treatments**

Other treatment approaches are available as an alternative, or as an adjunct, to individual child psychotherapy. These include family therapy, group therapy, 12-step and support groups, expressive therapies (e.g., art, writing, psychodrama), behavior modification, guided imagery, Eye Movement Desensitization and Reprocessing, nutritional consultation, and medication. Your child's therapist may provide some of these and can provide referrals for the other approaches.

Initial here if this section has been read and understood \_\_\_\_\_

### **Length of Psychotherapy**

Some psychological problems in children can be alleviated in a few sessions. Others require years of treatment. It is often difficult to predict the length of therapy needed. Some disorders cannot be properly treated within the limitations of some health plans.

The decision to terminate therapy belongs to the parent or legal guardian, except in cases in which the decision is that of the child at a certain age, e.g., cases involving issues of child abuse, substance abuse, and severe need.

Terminating therapy with a child should be done over a number of sessions, particularly in cases of a long-term therapeutic relationship. Should you or your child decide to terminate therapy prior to the

child's therapist's recommendation, it is important that your child have a final meeting with his/her therapist.

If your child's therapist believes you are terminating your child's therapy before adequate treatment has been received for your child's psychological problems, your child's therapist will provide you with referrals for other therapists or you may choose to continue therapy with your current therapist.

Initial here if this section has been read and understood \_\_\_\_\_

### **Psychotherapy Fees**

Psychotherapy sessions: \$ 140.00 per 55 minutes including any time missed by being late. Therapist reserves the right to periodically adjust the fee. Client will be notified of any fee adjustment in advance.

From time-to-time, therapist may engage in telephone contact with parent/guardian or client for purposes other than scheduling sessions. In addition, therapist may engage in telephone contact with third parties at parents/guardian's request along with advance written authorization. Parents/Guardians are responsible for payment of the agreed upon fee of \$30.00 per 15 minutes for any telephone calls longer than ten minutes with time rounded up to the nearest 15 minute increment. (Ex. If phone call is 23 minutes, time will be rounded to 30 and fee will be \$60.00)

Missed appointments or a cancellation with less than 24 hours notice, unless there is a medical emergency: client will be charged a \$50 no show fee.

Letters and reports (non-legal matters): \$ 150.00 per hour.

Testimony, court appearance, travel time, and preparation of written documents, meetings, phone consultations, in legal proceedings initiated by you or others relating to your child's case: \$ 200.00 per hour.

I understand that payment is due at each session.

Initial here if this section has been read and understood \_\_\_\_\_

### **Appointment Scheduling and Cancellation Policy**

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your child's therapist may suggest a different amount of therapy depending on the nature and severity of your child's concerns. Your child's consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your child's therapist at least 24 hours in advance of your child's scheduled appointment. If you do not provide your child's therapist with at least 24 hours notice in advance or do not show for your session, you will be charged a \$50 no show fee. Please note that your insurance company will not pay for missed or cancelled sessions.

Initial here if this section has been read and understood \_\_\_\_\_

## **Therapist Availability/Emergencies**

Telephone or email consultations between office visits are welcome. However, your child's therapist will attempt to keep those contacts brief due to the belief that important issues are better addressed within regularly scheduled sessions.

You may leave a message for your child's therapist at any time on her confidential voicemail. Non-urgent phone calls are returned during normal weekdays (Monday through Friday) and will be returned within 24 hours. Your child's therapist is not able to return phone calls after 8pm, and is not available to return phone calls on Saturday or Sunday. If you have an urgent need to speak to your child's therapist, please indicate that fact in your message. In the event of a medical emergency or an emergency involving a threat to your child's safety or the safety of others, please call 911 to request emergency assistance.

You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis:

- Emergency Psychiatric Evaluation in Orange County - 24 hours a day, 7 days a week, 365 days per year: (714) 834-6900 or 1-866-830-6011 – this number can gain you access to a mobile assessment team that can respond to a psychiatric emergency occurring somewhere in the community. The team can provide evaluation for individuals, assist with any necessary referrals, and provide transportation to a local hospital if needed.
- National Suicide Prevention Lifeline: 1-800-273-TALK (800-273-8255) - 24 hours a day, 7 days a week
- Crisis Hotline: (714) 639-4673
- Youth Crisis Hotline: 1-800-HIT-HOME (800-448-4663) - 24 hours a day
- College Hospital Crisis Response Team: 1-800-773-8001 - 24 hours a day
- Domestic Violence Hotline: 1-800-799-SAFE (800-799-7233) 24 hours a day
- Rape Crisis Hotline: (714) 957-2737 24 hours a day
- Sexual Assault Victim Services : (714) 834-4317

Initial here if this section has been read and understood \_\_\_\_\_

## **Psychotherapy Contract for Parents or Guardians of Child Clients**

I have read the above information, have asked questions as needed, and understand the issues related to risks and benefits of psychotherapy, medical concerns, assessment, the need for children and adolescents to have confidential psychotherapy, collateral contacts with parents and others, treating children of separated or divorced families, professional records, confidentiality from third parties, alternative treatments, anticipated length of treatment, psychotherapy fees, appointment scheduling and cancellation policy, and therapist availability/emergencies.

If you have complaints regarding the practice of your psychotherapist, you may contact the Board of Behavioral Sciences at 1625 N Market Blvd., Suite S-200 Sacramento, CA 95834.

I have discussed the issues addressed in this document with my child's therapist. Initial: \_\_\_\_\_

I agree to treatment for my child based on my informed wish to proceed.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Malaika Clelland, LCSW, RPT-S

\_\_\_\_\_  
Date