Barney Greenspan, Ph.D.
1500 East Heritage Park Street – Suite 125
Meridian, ID 83646
208 884 1205

Informed Consent for Work with Children and Adolescents

To be completed by parent, custodial parent or legal guardian

Note: The state of Idaho expects that you will be informed of all possible contingencies that might arise in the course of short and long term therapy with your child. Please check to be sure you have read, understood and discussed all questions with the therapist. An informed consent has the force of contract, so I may not proceed until we reach an agreement on all items.

Please print
Name of Child or Adolescent: _____ Sex: M___ or F ___

Age: ____ Birth Date: _____ Child's Phone Number: (___) _____-_____

Child's, or Adolescent's, Social Security Number: _____-_____-_____

Note Legal Custody: If parents are legally separated or divorced, or the child or adolescent is otherwise under custodial care or guardianship, you must submit with this informed consent the documentation giving you the legal right to pursue psychological treatment for the child or adolescent.

Please print
Parent, Custodial Parent or Legal Guardian's Name: _____

Address: _____-_____
Street City State Zip
Phone (home): (_____)_____-_____

Phone (work): (_____)_____-_____ Referred by: _____

Phone (cell): (_____)_____-_____ Social Security Number: ____-___-____ Birth Date: _____

Insurance Assignment: I hereby authorize my insurance benefits to be paid directly to Dr. Barney Greenspan. I further authorize Dr. Barney Greenspan to release information required to process claims for his professional services. Dr. Greenspan will request a copy of your insurance card to ensure accuracy; otherwise, fill out this indented section.

Insured's Name (if different from parent, custodial parent or legal guardian): _____

Name of Medical Insurance: _____ Insurance Phone #: (____)_____-_____

Address of Insurance: _____-_____
Street City State Zip

Group Number: _____ Policy Number: _____

Birth Date: _____ Social Security Number: ___-___-_____

Employer of Insured Person: _____

Name of Worker's Comp.: _____ Phone Number: (____)____-_____

Claim Number: _____ Adjuster's Name: _____

Signature: _____ **Date**: _____

Financial Policy: You are personally responsible for your entire bill regardless of any amount that may be covered by your insurance or a third party payer. Please call your insurance company and confirm your "outpatient mental health" benefits. As a courtesy, Dr. Greenspan will submit a claim to your primary insurance company. S*econdary insurance plans will not be billed.*

This office takes cash or checks. Credit cards are not accepted. There will be a charge of $25.00 for any returned check due to insufficient funds. If your child or adolescent will be attending their appointments unaccompanied, please choose how you will make their payment each session.

Cash _____ or Check _____

If your child or adolescent is being seen due to a court order or other legal matter, it is not certain that insurance will cover the services. Please inform Dr. Greenspan if these circumstances pertain.

Cancellation or No Show Policy: Because your appointment time is set aside specifically for the child or adolescent, there may be a charge of **$80.00** for any missed appointment, except for illness, if not cancelled at least **24 hours prior** to the time of the appointment.

Confidentiality: This section is condensed from the Idaho Notice Form for HIPAA. State law, and professional ethics, requires therapists to maintain confidentiality, except for the following situations:

1. If there is suspected child abuse.
2. "Tarasoff" situations in which serious threat to a reasonably well-identified victim is communicated to the therapist.
3. When threat to injure or kill oneself is communicated to the therapist.
4. If you are required to sign a release of confidential information by your medical insurance.
5. If you are required to sign a release for psychotherapy records if you are involved in litigation or other matters with private or public agencies. **Think carefully and consult with an attorney before you sign away your rights.** We can discuss foreseeable possibilities together.
6. Clients being seen in family therapy are obligated legally to respect the confidentiality of others. The therapist will exercise discretion (but cannot promise absolute confidentiality) when disclosing private information to other participants in the treatment process.
7. I may, at times, speak with professional colleagues about our work without asking permission, but all identities will be disguised.
8. My Executive Administrator has access to locked records, but is legally charged with confidentiality.
9. Clients under age 18 do not have full confidentiality from their parents.
10. It is also important to be aware of other potential limits to confidentiality that includes the following:
    - All records may be subject to court subpoena under certain circumstances. All records are stored in locked files.
    - Cell phones, faxes and emails are used on some occasions; any electronic communication may malfunction, thus resulting in compromised confidentiality.

For your convenience, the parent, custodial parent or legal guardian may be called in advance of an appointment as a reminder. If you do not want your home or work to be contacted for confidentiality reasons, please tell Dr. Barney Greenspan or his Executive Administrator.

I have read, and understand, the above policies.

Signature: _____ **Date**: _____
Parent, Custodial Parent or Legal Guardian

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE

IDAHO NOTICE FORM FOR HIPAA

Signature: _____ **Date**: _____
Parent, Custodial Parent or Legal Guardian