NORTH MARIN COMMUNITY SERVICES
YOUTH AND FAMILY COUNSELING PROGRAM
INFORMATION AND CONSENT FOR TREATMENT
STATEMENT OF CONFIDENTIALITY

The North Marin Community Services, as part of our support of the Novato Community, offers professional counseling to children and to their families and/or guardians.

I/We, _____ mother/father/guardian, consent for myself and my minor child (ren), _____ to voluntarily participate in the counseling program at the NMCS.

Please read carefully, initial each of the following items, and sign at the bottom of this form.

___ **NMCS Family Counseling Program Staff:** I/We understand that the Family Counseling Program staff includes licensed therapists and graduate/post graduate level trainees and interns. Each intern/trainee is supervised by a licensed clinician. Counselors make a one-year commitment in August and may or may not recommit at the end of one year.

___ **Confidentiality Policy:** I/We understand and agree that all information, communications, art work, observations and opinions derived from this counseling shall be considered private and confidential between myself and the NMCS Family Counseling Program. I/We understand that information may be shared within the agency for the purpose of consultation in order to provide the best quality of care. I/We understand that our records are confidential and will not be released to anyone without your written consent.

___ **Exception to Confidentiality:**

- If there is suspicion of child or elder abuse.
- If there is considerable danger to self (suicidal) or to others (homicidal).
- If there is disclosure of a sexual nature involving minors that meets the criteria for a report. Please ask your counselor for specific information.
- Upon the receipt of a court order.
- In the event of a valid medical emergency.

___ **Audio and Video Recording:** I/We authorize the North Marin Community Services to have selected counseling sessions observed, video taped and/or audio taped. I/We understand that any observation or recording will be treated with complete confidentiality; will be discussed for ongoing training and educational purposes with agency staff/interns and graduate school supervisors; will be kept in a safe locked area and will be erased once they are no longer needed for training.

___ **Cancellation Policy:** Since the scheduling of an appointment involves the reservation of time specifically for you and/or your child, a **minimum of 24-hours notice** is required to reschedule or cancel an appointment. For therapy to work, your attendance needs to be consistent. Consequently, if you miss two

appointments in a row without prior cancellation and rescheduling, therapy will be cancelled. Even with prior notice, cancellations that interfere with making progress may result in the need to end counseling.
If my child or I cannot attend a scheduled session, **I agree to pay for the missed session unless I have notified the counselor at least 24 hours in advance**. The fee for the missed session is due at the next session. I understand it will be necessary for me to pay any balance due before rescheduling an appointment.

___ **Alcohol and other drugs:** I agree not to arrive at any counseling session while under the influence of alcohol or other drugs.

___ **Medication:** I agree to inform my counselor of any medication I or my child are taking that might in any way effect my participation in counseling.

___ **Fragrances Policy:** A number of the staff and clients at the NMCS are sensitive to the chemicals contained in fragrances. I will refrain from wearing perfume, cologne or other fragrances to my counseling sessions. (Thank you)

___ **Fees and Policies:** I agree to pay **$30 per 50 minute session and/or $50 per PCIT 50 minute session**. Fees are due at each session unless other arrangements have been made. Cash or checks made payable to the North Marin Community Services Family counseling are acceptable forms of payment. I understand the NMCS will charge me $25.00 for returned checks. Fees will be reassessed on a yearly basis.

___ **Emergency procedure**: If an emergency arises, you can call your therapist at this number at (415) 892-1643 ext. _____. If you need immediate assistance call (415) 499-6666 or 911.

___ **Termination**: I agree that I will give my counselor notice before ending therapy and attend at least two final visits, as closure is an important process.

___ **Arrival for appointments at the NMCS**: when I/we arrive for our scheduled appointments, I/we will wait in the reception area of the clinic.

I have read, understood and agree to the above.

_____		_____	
Parent/Guardian's Signature	Date	Parent/Guardian's Signature	Date
_____		_____	
Address	Zip	Address	Zip
_____		_____	
Minor Child's Signature	Date	Minor Child's Signature	Date
_____			
Counselor's Signature	Date		