JESSICA ANNE DEEB, LCSW, LLC

CONTRACT/CONSENT FOR TREATING MINORS

MY GOALS

- Clarify that the "client" is the child/adolescent- not the parent, nor is this family therapy.
- Keep my client's safe if I believe they are in real and immediate danger to self/suicide or harming another.
- Improve the well-being of my client according to my client's (not the parent's or my) expressed treatment goals.
- Create an atmosphere of complete privacy, trust, and respect with my client. I am not a parent-figure.
- Enhance the client-parent relationship.

INFORMATION SHARED

- If it is necessary to refer out to another mental health professional with more specialized skills.
- Missed/unattended sessions.

INFORMATION NOT SHARED

- Information shared to me without your child's consent.
- Problematic or risky behavior, including but not limited to: alcohol, drugs, sex/STDs/pregnancy/abortions, cutting, burning, throwing up, lying, etc.
- You are waiving your right to access to your child's treatment records**.**

IMPORTANT CONSIDERATIONS

- REMINDER
  Your child may begin to feel more empowered. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

- PARENTAL INVOLVEMENT
  If you wish to share your thoughts or events that have occurred in between sessions, I will need for you to do that during our session time and with your child present.

  Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child.

- PARENT-THERAPIST DISAGREEMENT
  We can strive to resolve this or agree to disagree, so long as this enables your child's therapeutic progress. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention.

- LEGAL ISSUES
  Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

  (continued)

JESSICA ANNE DEEB, LCSW, LLC

CONTRACT/CONSENT FOR TREATING MINORS

- LEGAL ISSUES (continued)

  Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at our established hourly rate for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs. This rate is subject to change at Jessica Deeb's discretion. All fees associated with court related services will need to be paid in advance.

- TERMINATION
  If you (parent/guardian) decide to terminate treatment, I have the option of having a few closing sessions with your child to properly end the treatment relationship.

I have read the Contract for Treating Minors, and I give my permission to Jessica Anne Deeb, LCSW, LLC to provide mental health services to my/our child.

_____

Print Name Signature of Guardian Date

_____

Print Name Signature of Guardian Date

_____

Print Name Signature of Minor Date

_____

JESSICA ANNE DEEB, LCSW, LLC

CONSENT TO TREATMENT

CONFIDENTIALITY

Information shared during a counseling session is considered confidential under HIPPA (the Health Information Privacy and Portability Act). **However, there are some exceptions when your privacy is not protected by me that you should know about.**

1. All information will be held confidential and privileged unless the psychotherapist has suspicion that I (client) have **neglected or abused a child (including minors witnessing domestic violence), a senior citizen or a disabled person**, in which case a report will be made as required by law to the appropriate law enforcement and social welfare agencies.

2. All information will be held confidential and privileged unless I (client) report **suicidal or homicidal ideation, intent or plan,** in which case a report will be made as required by law to the appropriate law enforcement and social welfare agencies.

3. All information will be held confidential and privileged unless the psychotherapist has been **subpoenaed by a court of law**.

4. If I am utilizing **insurance or EAP** to assist in payment for my services, I agree by my signature below to allow my psychotherapist to release information in my record, including but not limited to: my history, condition, diagnosis, prognosis, treatment plan and treatment recommendations to insurance/EAP personnel involved in reviewing my case.

5. Other information may be released in accordance with the **Heath Insurance Portability and Accountability Act** as described in this office's Notice of Privacy Practices.

You have the legal right to have *access* to your therapy file. If requested, you will be provided with a **professional summary**. A professional summary includes: the dates of our sessions, our treatment goals, a summary of our sessions, and a synopsis of your progress in therapy. My detailed session notes are to help me process my thoughts and remain my legal property (though strictly confidential to no one but myself). Anyone seeking access to their file will be provided with a summary within 10 business days at the rate of $25 per report. Anyone else wishing to access your file will first need you to come into the office and sign a release permitting the release of your information.

☐ I agree to receive telephone calls, text messages or phone messages from this office to the telephone contact numbers I have provided.

☐ I agree to receive e-mails or physical mailings (to the home address I have provided) from this office.

☐ I have received a copy of the Notice of Privacy Practices adhered to by this office.

_____

Print Name Signature of Client Date

_____

9400 River Crossing Blvd., Ste. 102, New Port Richey, 34655 • 105 S. Albany Ave., Tampa, 33606

Office 1-727-808-4818 • Fax 1-727- 375-8631 • www.jessicadeeb.com

Print Name Signature of Counselor Date

CONSENT TO TREATMENT

FEE SCHEDULE

The costs for counseling sessions vary from $70-$100 per 50 minute session according to my sliding fee schedule (based on your gross annual/family income and family size). If you wish to pay less than the normal $100 fee you will be asked to provide last year's tax return and together we will decide what rate works best for you. If your financial situation changes for the better or worse during our work together, please let me know so we can adjust your rate accordingly. See chart.

Counseling services are not provided outside of face-to-face sessions.

While phone and/or Skype sessions are not the norm, they may occur from time to time in the case of a crisis. Phone/Skype sessions are subject to the same sliding fee schedule as mentioned above. Phone/Skype sessions will be billed and due upon receipt.

All client emails, writings/journals, and anything you would like for me to read will be collected and saved for our next session.

I do not assure availability at all times and the practice is not geared to the provision of emergency services. Should there be a psychiatric emergency and I am not readily available to assist you in making arrangements, call 9-1-1 or go to the nearest emergency room. If you live in New Port Richey, you can also call BayCare's crisis line at 727-841-4439. If you live in Tampa, you can also call the Crisis Hotline at 813-234-1234.

There are fees for special services. These fees include, but are not limited to, the following:

1. Preparation for any **reports, forms, or other administrative requests** at our established hourly rate.

2. If I participate in a **legal case, regardless of which party's attorney calls or subpoenas me, fees include but are not limited to testimony, time for travel, waiting in the courtroom, telephone conferences, depositions and review notes.** Each of these fees are set at our established hourly rate. In addition, you are responsible for any **fees that I incur by your attorney**.

3. Finally, the above established fee per session will be charged for **face to face consultations held on your behalf with other professionals/agencies** at our established hourly rate.

Please note that you will be responsible for the entire cost of a session when cancelled in less than 24 hours. For those with insurance, be aware that insurance does not cover missed sessions, and you are responsible for the total contracted rate. This includes sessions cancelled if you are called into work, have transportation issues, are sick, mistaken appointment times, etc.

Fees are to be paid in full the day of your session- at the beginning of the session.

Cash, checks, money orders, cashiers check, and credit cards are accepted. If you are paying with check, please have your check already prepared and ready before your session starts. Please make your checks out to: Jessica Anne Deeb, LCSW, LLC. Bounced checks will be subject to a $30 fee due at the time of receipt.

_____

Print Name Signature of Client Date

_____

Print Name Signature of Counselor Date

CONSENT TO TREATMENT

FEE SCHEDULE (continued)

My services will be funded as follows:

☐ **Self Pay**:

My fee for services will be $_____for the initial 50 minute session.

My fee for services will be $_____per 50 minute session.

☐ **Health Insurance**: _____.

My annual deductible is $_____.

My copay is $_____per 50 minute session.

My sessions are limited to _____ per year.

☐ **Employee Assistance Program** (EAP): _____.

My sessions are limited to _____ per year. There is no copay for EAP services.

TERMINATION

It is my standard office policy to terminate counseling services for any client whom I have not counseled within 30 days of the last service. At that time, I will contact you asking if you wish to continue counseling services. If I do not get a response within 10 days of contact made, I will assume you wish to terminate services and will remove your name from my active client list. Of course, you are welcome to call for an appointment as a new client at any point in the future. However, I reserve the privilege to accept new clients or not, depending on a host of factors including case load and time allocation.

_____

Print Name Signature of Client Date

_____

Print Name Signature of Counselor Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice specifically describes the policies of Jessica Anne Deeb, LCSW, LLC's mental health practice. Affiliated providers (for example, counselors other than Jessica Anne Deeb, LCSW, LLC who rent space in this office) may have different privacy practices from those described in this Notice. Please contact affiliated providers directly for more information about their privacy practices. References to "we," "our" or "us" in this Notice refer specifically to the policies and practices of Jessica Anne Deeb, LCSW, LLC.

Acknowledgment of Receipt of This Notice

You will be asked to provide a signed acknowledgment of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your services will not depend upon your signed acknowledgment. If you decline to sign an acknowledgment, we will continue to provide you with services. However, we will also use and disclose your protected health information for provision, payment, and reporting of services, when necessary, as described in this Notice.

Our Responsibilities Regarding Your Protected Health Information

We understand that your medical and health information is personal and that protecting your health information is important. "Protected health information" is individually identifiable health information which includes items such as name, age, address, social security number, e-mail address, etc. We follow strict federal and state laws that require us to maintain the confidentiality of your health information. We are required by law to do the following:

- Maintain the privacy of your health information
- Provide this Notice that describes the ways that we may use and share your protected health information
- Follow the terms of the Notice currently in effect.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Your records will be retained by us for approximately seven years after your last date of service at this office. After that time has elapsed, your records will be erased, shredded, burned or otherwise destroyed in a way which protects your privacy. Copies of mental health records generated by this office which have been distributed to other entities may continue to exist under the privacy policies established by those entities. Until your records are destroyed, they may be used for the following purposes:

For Required Uses and Disclosures

We may disclose health information to the Secretary of the Department of Health and Human Services (DHHS) for investigations or determinations of our compliance with laws on the protection of your health information.

For Treatment

We may use and disclose your protected health information to provide your care and any related services. This includes the coordination or management of your health care with a third party. For example, we might disclose your protected health information to a therapist who is co-leading a therapy group in which you have asked to participate at this office. We might also disclose your information to a

professional colleague who provides us with clinical consultation services. Any person or entity with whom your information is shared will also be required to comply with federal privacy practices regarding your protected health information.

To Obtain Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, your information may be shared with an insurer who provides reimbursement for your services at this office.

For Health Care Operations

We may use or disclose, as needed, your protected health information to support quality assessment activities. For example, your information may be used in our self-monitoring exercises for the purpose of continuing improvement. We also may use or disclose your protected health information to provide you with appointment reminders or information about other health-related programs and services. For example, your name and address may be used to mail you mental health newsletters or periodic announcements about therapy groups or workshops sponsored by this office which might be of interest to you.

As Required by Law

We may use or disclose your protected health information if law or regulation requires the use or disclosure of your information.

For Public Health and Safety

We may disclose your protected health information to a law enforcement or human welfare authority or other entity in order to: report suspected abuse or neglect of any individual in a "protected population" (minor children, disabled individuals, or the elderly); or to protect you and others if we believe you are at imminent risk of harm to yourself or others.

JESSICA ANNE DEEB, LCSW, LLC

ADOLESCENT INTAKE/ASSESSMENT

Date: _____Client (Adolescent) Name: _____

Client DOB: _____Client Age:_____Client Cell Phone: _____

Bio Mother's Name: _____

☐ Custody: joint / primary / sole Visitation Schedule: _____

Street: _____Apt/Bldg: _____

City: _____State: _____ Zip: _____

Cell Phone: _____ E-mail: _____

Home Phone: _____Work Phone: _____

Employer/Job Title:_____

Guardian/Step-Parent's Name: _____

Guardian Cell Phone: _____Gaurdian E-mail: _____

Bio Father's Name: _____

☐ Custody: joint / primary / sole Visitation Schedule: _____

Street: _____Apt/Bldg: _____

City: _____State: _____ Zip: _____

Cell Phone: _____ E-mail: _____

Home Phone: _____Work Phone: _____

Employer/Job Title:_____

Guardian/Step-Parent's Name: _____

Guardian Cell Phone: _____Gaurdian E-mail: _____

JESSICA ANNE DEEB, LCSW, LLC

ADOLESCENT INTAKE/ASSESSMENT

Emergency Contact (Name/Number): _____

School/Grade:_____

Special Needs:_____

Plans after high school:_____

Ideal job:_____

Religion/Spirituality:_____

Interests/Hobbies:_____

Positive Coping Skills:_____

REASON FOR COUNSELING (How long have you struggled with this):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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ADOLESCENT INTAKE/ASSESSMENT

FAMILY MEMBERS (parents, siblings, pets, etc)				
Ethnicity/Culture:				
Name	Relationship	Age	Current Type of Relationship (close, not speaking, etc.)	Current City/State

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CURRENT RELATIONSHIP STATUS		
Heterosexual Homosexual Bisexual Transsexual Transgendered Questioning Other_____		
Single Relationship Cohabit Married Separated Divorced Widowed Other_____		
How long?_____ Name of partner:_____ Age: _____ Open/Closed?		
NOTES:		
Any discontinued pregnancies? _____ How many full term pregnancies? _____		
RELATIONSHIP HISTORY		
Names of Select/Important Previous Partners (start with most recent)	Approx. Start/End Dates	Why ended

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ADOLESCENT INTAKE/ASSESSMENT

LIST A FEW OF THE MOST IMPORTANT (POSITIVE OR NEGATIVE) IN YOUR LIFE	
PEOPLE family, friends, support system, teachers, religious figures, counselors, heros, role models, pets, etc.	
EVENTS/LANDMARKS personal, familial, accomplishments, disappointments, legal issues/jail socio-political, etc.	
"T"RAUMA/"t"RAUMA emotional, physical, sexual, bullying, neglect, natural disaster, war, witnessing scary event, or something that doesn't seem that "traumatic" but really stayed with/affected you	
SPERATIONS/LOSS/DEATHS	
ANNIVERSARIES/DATES OTHER	

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ADOLESCENT INTAKE/ASSESSMENT

MEDICAL	
PAST ILLNESSNESS PROCEDURES, PREGNANCY COMPLICATIONS (WITH DATES)	
CURRENT ILLNESSES PROCEDURES AILMENTS HANDICAPS	

CURRENT MEDICATIONS				
Rx/Amount	Reason	Name of Doctor	Start/End Dates	Outcome

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ADOLESCENT INTAKE/ASSESSMENT

PLEASE CIRCLE ALL THAT APPLY	
HOUSING	live with family rent own other_____
TRANSPORT	car shared car rides bus bike
FINANCES	No Concerns Okay Temporary Difficulties Restrictive/Very Tight Debt
PHYSICAL	**Appetite:** no change decreased appetite increased appetite **Weight:** no change loss gain **Eating:** no issues restrictive binging overexcersing laxatives throwing up **Sleep:** no issues difficulty falling asleep intermittent waking early am waking difficulty waking nightmares not getting enough sleep **Energy:** no issues low energy excessive energy **Vision/Hearing/Dental/Mobility:** no issues Describe:_____
DEPPRESION	N/A down dissatisfied unhappy depressed sadness crying negative feels has more problems than others restless irritable angry hopeless numb life feels empty / boredom loss interest / motivation / pleasure difficulty concentrating can't make decisions poor functioning recent/big changes thoughts about death in general thoughts about suicide
CONNECTION	N/A overextending self detached isolated / lonely withdrawing friends & social events
SELF-ESTEEM	N/A low self-esteem inadequate feels like failure worthlessness excessive guilt not feel belong
ANXIETY	N/A anxious / nervous unable to relax pacing easily worn out overstressed muscle tension panic attacks: pounding heart, trembling, shortness of breath / smothering / feeling of choking, chest pain nausea dizzy lightheaded feelings of unreality / being detached from self numbness/tingling sensations, chills/ hot flushes, fear losing control /going crazy/dying need for order / perfection / rituals fear leaving home or going places without easy exit
COPING	alcohol drugs cutting burning risky behavior self-sabotage anger crying avoidance sleeping gambling shopping relationship/sex overrworking food control/order TV/internet other:_____
MENTAL HEALTH HX	N/A counseling / groups medication intensive programs / psychiatric hospitalization / rehab / detox Family Hx**:** N/A unknown depression anxiety mania substance suicide/ attempt psych hospital

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ADOLESCENT INTAKE/ASSESSMENT

SAFETY CONCERNS- SUICIDAL THOUGHTS	
1. Since when? 2. How often thoughts come up? 3. How long before can refocus? 4. Do you have a plan? What? 5. Rate your intent to act, 1-10? (10=Highest Risk) 6. Previous attempts/inpatient? 7. Anyone known attempt/complete? 8. What's keeping you from acting?	

COUNSELING GOALS-TREATMENT PLAN		
Rate (1= most important)	Problem	Goal

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