**Jason P. Winton, M.S.**

Licensed Marriage and Family Therapist

LMFT 85416

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530.354.1862

**AGREEMENT FOR SERVICE / INFORMED CONSENT FOR MINORS**

**Introduction**

Because therapy often begins in a situation of considerable emotional difficulty, I have prepared these notes so that you will have an understanding of our basic agreement. Please discuss any questions or concerns regarding our agreement with me prior to signing it.

**Policy Regarding Consent for the Treatment of a Minor Child**

I generally require the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of the parent or guardian to give consent for psychotherapy, I will require that the parent or guardian submit supporting legal documentation, such as a custody order, prior to the commencement of services.

**Therapist Background and Qualifications**

I have been practicing as a licensed marriage and family therapist (LMFT) since November 2014, working mostly with individuals and couples experiencing depression, anxiety, trauma, addiction, as well as assisting them with case management related to housing, employment, and medical care. Prior to licensure, I worked primarily with youth and families in a school-based counseling program to address many of the same issues listed above, as well as more youth-oriented concerns like inattention, hyperactivity, and disruptive behavior.

My theoretical orientation can be described as strengths-based, cognitive-behavioral, and contemplative. I often use elements of narrative therapy, solution-focused, and spirituality from the 12-step tradition.

**Process of Therapy**

A therapy session typically lasts 45 - 50 minutes. I encourage you and your child to "switch gears" before you arrive and take advantage of the entire session time.

**Risks and Benefits of Therapy:**

Participation in therapy can result in a number of benefits to you and your child, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on the part of the participants. Psychotherapy requires very active involvement, honesty and openness in order to change thoughts, feelings, and/or behavior. Therapy is an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties you may be experiencing. Although I certainly expect that psychotherapy will yield positive or intended results, there is no way to guarantee this.

Participating in therapy may result in a number of benefits to you and your child, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. This discomfort may also extend to other family members, as they may be asked to address difficult issues and family dynamics.

The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which I will challenge the perceptions and assumptions of you, your child, or other family members, and offer different perspectives. The issues presented by you and your child may result in unintended outcomes, including changes in personal relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Please discuss with me any concerns you or your child have regarding his/her progress in therapy.

**Discussion of Treatment Plan:**

Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of therapy, their possible risks, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If your child could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining these treatments, and will gladly do so.

**Terminating Treatment:**

Termination from therapy is an important process that can be of benefit to clients and therapist. I encourage my clients to partake with me in this process of finding out what was helpful and what could have been more helpful. It is your right to terminate therapy at any time. However, it is especially important for children to have an adequate time to say goodbye. I request that you and your child come in to discuss leaving and any feelings that may be associated with the process. If you choose to terminate, I am glad to provide referrals to qualified professionals. As your therapist, I have the right and duty to terminate therapy under the following circumstances: when I assess that treatment is no longer helpful or beneficial to your child, if I determine that another professional would better serve your needs, or if you have failed to show up for your last two sessions without the required 24 hour notice of cancellation. In all cases I am happy to provide you with resources and referrals as necessary.

**Telephone and Emergency Procedures:**

If you need to contact me between sessions, you may call or text me at my cell phone (530-354-1862). In most cases, you will need to leave me a message and I will respond at my earliest convenience. If an emergency arises, please indicate it clearly in your message. **If there is a life-threatening emergency, please call 911 or go to the closest emergency room.**

**Confidentiality**

An important aspect of the therapeutic relationship is confidentiality. Knowing that I will keep communications private helps to make this a safe place for you and your child to explore, to learn and to grow. Please be aware that the only exceptions to confidentiality are: 1) when you have given written consent for me to share information, 2) when I am required to do so by law, as in cases of suspected child, elder or dependent abuse, or actual or potentially dangerous behavior toward yourself, others, or other’s property, and 3) as required/allowed by HIPPA (please read the HIPPA form for further clarification of the privacy of your health information and records).

Psychotherapy can only be effective if there is a trusting a confidential relationship between your child and myself. I will meet with you regularly about your child’s treatment but will need to maintain some degree of confidentially to promote emotional safety for your child to feel free to be honest. I welcome any questions you may have about the therapy process and practices, so please feel free to discuss these with me. Parents/guardians can expect to be informed in the event of any serious concerns I might have regarding the safety or well-being of your child, including suicidality.

**Professional Consultation**

Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding the client or client’s family members or caregivers.

**Records and Record Keeping**

I may take notes during session, and will also produce other notes and records regarding client’s treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Such records are my sole property. Should a client, parents or guardian request a copy of my records, such a request must be made in writing. I reserve the right, under California law, to provide a client, or parent/guardian, with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Parent/guardian will generally have the right to access the records regarding client. However, this right is subject to certain exceptions set forth in California law. Should a parent/guardian request access to my records, such a request will be responded to in accordance with California law.

I will maintain client’s records for ten years following termination of therapy, or when client is 21 years of age, whichever is longer. However, after ten years, client’s records will be destroyed in a manner that preserves client’s confidentiality.

**Patient Litigation**

I will not voluntarily participate in any litigation, or custody dispute in which client, or parent/guardian, and another individual, or entity, are parties. I have a policy of not communicating with parent’s or guardian’s attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in client’s, or parent’s/guardian’s, legal matter. I will generally not provide records or testimony unless compelled to do so. In addition, I will not make any recommendation as to custody or visitation regarding a client. I will make efforts to be uninvolved in any custody dispute between a client’s parents.

**Psychotherapist-Patient Privilege**

The information disclosed by a client, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Client in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the client is the holder of the psychotherapist-patient privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-patient privilege on a client’s behalf until instructed, in writing, to do otherwise by a person with the authority to waive the privilege on client’s behalf. When a client is a minor child, the holder of the psychotherapist-patient privilege is either the minor, a court appointed guardian, or minor’s counsel. Parents typically do not have the authority to waive the psychotherapist-patient privilege for their minor children, unless given such authority by a court of law. Parents/guardians are encouraged to discuss any concerns regarding the psychotherapist-patient privilege with his/her attorney.

Client, or parent/guardian, should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Client, or parent/guardian, should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

**Fee and Fee Arrangements**

My intention is to assist the South Chico community by providing therapeutic and spiritual services for free (or, if you prefer, on a basis of “pay what you can”). All may contribute to the work of the free clinic, but my goal is to erase economic barriers for those who cannot afford to pay. Therefore, access to services is completely separate from monetary matters.

**Cancellation and Missed Appointment Policy**

I have reserved an appointment time especially for you. I request at least a 24 hour notice for cancelled appointments. Please note that it is important for you to attend your sessions on a regular basis. Please help me to continue to provide the best service to our clients by honoring your appointment time. Two consecutive missed appointments could result in termination of therapist. In order to cancel an appointment, please leave me a message at 530-354-1862.

**Acknowledgement**

By signing below, I acknowledge that I have reviewed and fully understand the terms and conditions of this Agreement. I have discussed such terms and conditions with Jason Winton, and have had any questions with regard to its terms and conditions answered to my satisfaction. I agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with Jason Winton. I agree to hold South Chico Free Clinic and Jason Winton free from any and all liability, loss or damage of any kind that may arise as a result of assistance that I receive.

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Client Name (please print) Date

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Client Signature (if client is 12 or older) Date

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Parent/Guardian Signature (and relationship to client) Date

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Parent/Guardian Signature (and relationship to client) Date

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Therapist Signature Date