PATIENTS AGES 13-17 YEARS
SUPPLEMENTAL TO PATIENT DISCLOSURE AND CONSENT FOR
PSYCHOLOGICAL SERVICES DOCUMENT
EFFECTIVE 09/01/2016

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Consent and Confidentiality for Patients Ages 13-17 Years

In Washington State, you can consent to your own mental health treatment at the age of 13 years. This means that your parent(s) or guardian(s) cannot legally have access to your records without your written permission. When providing treatment to patients between the ages of 13 and 17 years, I follow the same confidentiality guidelines as I would for an adult (outlined below and in Patient Disclosure and Consent for Psychological Services document), with one exception: If the minor informs me of behavior that puts him or her at risk of harm, regardless of whether or not I must, by law, disclose this information to authorities, I may discuss the information with the parent(s) or guardian(s) of the minor. Before disclosing such information and involving the parent(s) or guardian(s), however, I may discuss the need to do so with you and attempt to come to an agreement about how the information will be disclosed. It is your safety and best interests that I prioritize in these situations, and I evaluate each situation individually before taking action.

If you are paying for psychotherapy or evaluation services with your parent's or guardian's medical insurance, you should know that your parent or guardian will receive an Explanation of Benefits (EOB) for each visit, as is standard for any procedure billed to an insurance company. The EOB will disclose the code we are using for the diagnosis. If you do not want your parent or guardian to have this information, I can talk with you about contacting the insurance company.

Furthermore, if a parent or guardian is paying for any portion of your psychotherapy or evaluation services, I will obtain your written permission to discuss billing and financial matters with your parent or guardian. You must be willing to give consent for me to discuss financial matters with your parent or guardian if applicable.

If you are receiving assessment services, you may choose to provide permission for me to discuss information relevant to the evaluation with your parent(s) or guardian(s), including but not limited to results, findings, recommendations, and treatment planning. Similarly, you may choose to provide permission for me to discuss information relevant to the evaluation with your teachers and school staff, including but not limited to results, findings, recommendations, and treatment planning.

Confidentiality

Confidentiality is an essential element to all assessment, evaluation, and psychological services, particularly psychotherapy. It is important that you know that your communications with me are private, yet certain limitations exist. The law protects the privacy of all communications between a patient and a psychologist. In most cases I can only release information about your treatment to others if you sign a written Authorization for the release of information form that meets certain legal requirements imposed by Washington state law and/or HIPAA.

There are some situations in which I am legally obligated to take actions in which I may have to disclose information about a patient without the patient's consent or written authorization. If such a situation

arises, I will limit my disclosure of information to what is necessary. Although these situations are unusual in my practice, they include:

- If I have reasonable cause to believe that a child, elderly, or vulnerable or dependent adult has suffered abuse or neglect, I am required to file a report with the appropriate state agency. Once such a report is filed, I may be required to provide additional information.
- If you have admitted any prenatal exposure to controlled substances that could be harmful to the mother or the child.
- If I have reasonable cause to believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
- If the patient threatens to harm herself or himself, I may be obligated to seek hospitalization for her or him and/or contact others who can help provide protection.
- Per Washington state law, I must report to the state licensing board any instance where a healthcare provider (including psychologists, therapists, physicians, or allied healthcare professionals) is impaired, behaves unprofessionally, or engages in sexual misconduct with a client. If you are a health care provider and my patient, your confidentiality remains protected under this law.

Other situations in which disclosure of confidential information may be required include court orders, claims with Labor and Industries, government oversight, or if a patient files a complaint or lawsuit against me.

While this written summary of exceptions to your confidentiality should prove helpful in informing you about potential disclosures, it is important that we discuss any questions or concerns that you may have now or in the future. Additional information is contained in the HIPAA Notice of Privacy Practices document you have received. The laws governing confidentiality can be quite complex and I am not an attorney. In situations where specific advice is required, formal legal advice may be pursued.

You should be aware that I consult with other health and mental health professionals at times. These professionals are legally bound to keep the information confidential, additionally any such consultations are noted in your clinical record and considered PHI. Disclosures required by health insurers and to collect overdue fees are discussed above.

Unless with mutual written consent, neither you nor I may record sessions or phone calls.

Signing this Agreement

Once you have read and understand this agreement, please sign below. If there is any portion of this agreement that you do not understand or about which you have questions, please discuss it with me before signing below. Your signature also acknowledges that you have read and understand this agreement, have had all of your questions answered, you agree to the terms of this agreement, have received a copy for yourself if requested, and have been provided access to a copy of the Patient Disclosure and Consent document described above and attached to this document.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Patient/Guardian refuses to acknowledge receipt

Psychologist Signature: _____ Date: _____