North Hills Psychological Associates, Inc. (NHPA)

Agreement for Psychological/Psychotherapy Services for a Minor

Client (child's) Name _____ Date of Birth _____

I, _____, the parent/legal guardian of the minor noted above give my permission for this child to receive psychotherapy/psychiatric evaluation and/or treatment. I understand that by signing this Agreement I am giving permission for my child to receive services and for the clinician to interview those persons necessary for such treatment. I also agree that:

1. I have the right to provide information to NHPA so that they may make appropriate assessments and recommendations.
2. I have the right to work with NHPA to determine a mutually agreeable Treatment Plan and discuss any concerns or questions I have regarding these professional or administrative services.
3. I understand that no promises have been made to me as to the results of any treatment provided by NHPA.
4. I understand that certain information regarding the therapy, with the exception of imminent danger, threat of harm, or suspicion of child abuse, may be kept confidential from parents, at the discretion of the provider.
5. If I schedule appointments, I will respect my commitment to follow up appointments and keep the appointments that I have scheduled. If I am unable to keep an appointment I will give at least 24 hours notice. If I do not give this notice I will be responsible for fees of $50 for No Show and $25 for Cancellation without 24 hours notice.
6. If I schedule appointments, I agree that I will be responsible for payment of a $10 fee if I do not pay my copay at the time of service.
7. I will keep NHPA staff informed of my current contact information and insurance coverage.
8. I authorize direct payment to NHPA of any insurance benefits otherwise payable to me for provided services. I also authorize my insurance company to furnish NHPA information pertaining to my insurance benefits and the status of claims submitted by NHPA for services rendered.
9. I consent to the release to my health plan or insurance company, (if I am the policyholder of insurance for the minor client), the medical information necessary for NHPA to secure payment for services rendered.
10. I understand that some behavioral managed care companies want to review complete records of some patients. You may release my child's records without obtaining an additional release.
11. **I am aware that requesting the release of treatment plans, notes or reports for forensic purposes, or subpoenaing testimony about any of the content of my child's treatment interferes with the therapy relationship and greatly jeopardizes his/her health and wellbeing.** Therefore, I knowingly and freely waive my right to request the release of information (other than dates of sessions, length of sessions, attendance at sessions, and fee information) to my attorney or the Court. I understand that release of clinically-significant information to the Court shall be by Court Order, signed by a duly appointed Judge, only. I further understand, that if I violate this agreement and attempt to involve the therapist in a court/custody dispute, I will be billed for the therapist's time for these legal issues, at a rate of $4.76 per minute, including, but not limited to, responding to attorneys, phone calls, writing reports, supervision, preparing for court appearances, travel to and from court, etc. I understand that payment for these charges is the responsibility of the parent or guardian requesting them, regardless of any custody order.

Signed _____ Date _____ Witness _____ Date _____

Parent/Legal Guardian **Please note that a witness signature is required.**

Please print: Name: _____

Address: _____

Phone: _____

10475 Perry Hwy
Town Centre, Suite 300
Wexford, PA 15090

200 Cedar Ridge Drive
Cedar Ridge Business Park, Suite 204
Pittsburgh, PA 15217

6315 Forbes Ave
Maxon Towers, Suite B13
Pittsburgh, PA 15217