Allison S. Kress Psy.D. (PY 60558205)

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NOTIFICATION OF INFORMED CONSENT MINOR

It is recommended by the Board of Psychology that clients be informed of the following before consenting to treatment.

Consent for Treatment: I, (print name)_____, authorize and request that Allison S. Kress, Psy.D. provide psychological examinations, treatment, and/or diagnostic testing which now or during the course of my care as a patient are advisable. The frequency and type of treatment will be decided between me and Dr. Allison Kress. I understand that the purpose of these procedures will be explained to me and are subject to my verbal agreement.

Limits to Confidentiality: I understand that my case information is confidential and clinical notes, psychological testing results, and other relevant case information will not be released to any other party without my written consent (verbal consent in an emergency). However, I also understand that Dr. Allison Kress is a mandated reporter of suspected child, elder, and dependent adult abuse by law and, therefore, must report to the proper authorities should they become aware of any previously unreported abuse of the aforementioned. Additionally, I also understand that should I pose a potential danger to another (C.C. 43.92 Violence Reporting Act) or a danger to myself (E.C. 1024) that the law requires that this information be reported to the proper authorities

Risk of Treatment: I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur. I understand that the maximum benefit will occur with consistent attendance and that at times I may feel conflicted about the therapy as the process can sometimes be uncomfortable.

Fees/Collections: I understand that a fee arrangement will be made with me at the commencement of treatment and that payment is due prior to or at the time of each 50 minute session. I also understand that checks returned for nonpayment will result in an additional $25 charge for administration costs. All payments for services rendered are private pay (i.e. health insurance not accepted). Upon request, you will be provided with a receipt to submit to your insurance company for a possible reimbursement. Please note that you are responsible for checking status of benefits, submitting receipts, and securing reimbursement. Any changes in the fee arrangement must be made directly with Dr. Allison Kress. I also understand that if I fail to pay for services promptly collection action may be taken. I will be responsible for any attorney fees and other collection costs.

Emergency: Therapist's office is equipped with a confidential voice mail system that allows Client to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Client is feeling unsafe and requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

Termination and Referral: Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to: untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Client needs are outside of Therapist's scope of competence or practice, or Client is not making adequate progress in therapy. Client has the right to terminate therapy at his or her discretion. I also understand that the purpose of psychotherapy is to provide help and if I believe I have received unethical treatment with Dr. Allison Kress, can report the matter to the California or Washington Department of Consumer Affairs. Upon either party's decision to terminate therapy, Therapist will generally recommend that Client participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Client and/or Representative.

Informed Consent: My and my minor's signature below verifies that we have read and fully understand this Consent for Treatment Form.

_____ _____
Parent's Signature Date

_____ _____
Minor's Signature Date

_____
Print Minor's Name