Seattle Relationship Therapy, P.L.L.C.
1818 Westlake Ave. N. Suite 312
Seattle, WA 98109

CONSENT FOR TREATMENT FOR A MINOR:

If the patient is a minor, or for whatever reason not responsible for payment of the services rendered, the person signing this contract accepts full responsibility for the payment of the professional fees and agrees to all of the contract terms as specified herein for the professional services rendered to the patient. Billing statements are available for you to submit to insurance. Phone calls are not covered by insurance – phone calls in excess of 10 minutes will be charged at the prorated amount of your counselor's billing rate per 15 minute increment.

Any appointments not cancelled more than 48 hours in advance are charged at the full rate of the session you have scheduled. Please note: insurance does not pay for missed appointments.

In general, it is most therapeutic for payment not to be made through or in front of the child receiving services, as most children feel guilty having their parents pay for the sessions. When seeing a child, we keep your credit card on file and charge it at the end of each session. Please fill out the following information to facilitate payment, which will be kept confidential and in a locked, secure location:

Credit Card #_____ Expiration Date: ___/____ CVV ____ Zip Code_____

Name on Credit Card: _____

Credit Card Billing Address: _____

PROTECTION OF CONFIDENTIALITY AGREEMENT

In order to facilitate and protect your child's therapy it is crucial that he/she be afforded strict confidentiality. It is not in a child's best interest to have their therapy in any way involved in parental disputes. It is in the best interest of the child and their parents that no one feels influenced by any impending legal action while involved in psychotherapy. Therefore, it is necessary that parents stipulate that I will not be requested or required at any time to provide clinical records or any information regarding a child's therapy for any manner of legal proceeding, including but not limited to divorce or custody disputes.

Parental signatures below acknowledge an understanding of the above agreements:

_____
Name of Patient

_____
Name of Parent Signature Date

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Name of Parent Signature Date