Terri Needels, Ph.D.
615 Piikoi St. • Suite 1603 • Honolulu, Hawaii 96814
(808) 596-8778 • Fax: (808) 596-8558

Terri Needels, Ph.D.

CHILD THERAPY AGREEMENT

This "Child Therapy Agreement" is for use in the complex situation which exists when the parents or guardians of a child or teen who is seeking my services, are divorcing, divorced, separating, or separated. Under those conditions, I ask you to agree to the following:

Consent to Treatment: In case where parents/guardians have joint legal custody, I will require written consent from both parents/guardians for me to work with their child/teen. Signing this letter of agreement will represent such consent. I will also require, prior to the first meeting, a copy of that portion of the divorce decree/court document describing the custody of the child/teen.

Confidentiality: To assist their child/teen in establishing a trusting and therapeutic relationship with me, parents/guardians are willing to waive their right to access their child's/teen's therapeutic information, including their statements made during therapy, except when the child's/teen's physical health and safety are in imminent jeopardy. Parents/guardians attest to this waiver by signing this agreement.

Forensic Matters: Parents/guardians understand that my role is to be their child's/teen's therapist. Unless ordered to do so by a court order signed by a judge, I will not provide information to a court or attorney, either orally or in writing, as this may compromise my therapeutic role. I may consider discussing information with a court-appointed professional who is functioning in the role of a custody evaluator or guardian-ad-litem, if that professional is obtaining information from a variety of sources. It is NOT part of my role as therapist to recommend any changes in custody or visitation.

Dual Role: If I am your child's/teen's therapist, I will NOT take on a second role, such as parent therapist, court evaluator, mediator, or expert witness for one parent.

Financial: The parent/guardian who brings/accompanies the child/teen to their session with me, or, if not in attendance, who scheduled that appointment, will be responsible for the co-payment or payment of my fee, whichever is appropriate for that visit.

Your signature below indicates that you understand and agree to the conditions specified in this agreement.

_____	_____	_____
Signature	Child / Children	Date
_____	_____	_____
Signature	Child / Children	Date

TERRI L. NEEDELS, PhD
Hawaiifamilytherapy@yahoo.com
615 Piikoi St, Suite 1603
Honolulu, HI 96814
Ph: (808) 596-8778 Fax: (808) 596-8558

AUTHORIZATION FOR EVALUATION/TREATMENT OF MINOR

PATIENT NAME _____ **DATE OF BIRTH** _____

1. CONSENT TO PSYCHOLOGICAL CARE
I give permission to Terri Needels, Ph.D. to provide clinical, educational, diagnostic testing and/or therapeutic services for my minor child, as deemed appropriate by her professional judgment. I am aware that the practice of psychology is not exact science and I acknowledge that no guarantees have been made to me as to the results of evaluation or treatment. I am also aware that I should ask Dr. Needels any questions that I might have about my minor child's diagnosis, treatment, risks or complications, alternative forms of treatment and/or anticipated results of treatment.

2. AUTHORIZATION FOR REVIEW AND RELEASE OF INFORMATION
I understand that Dr. Needels may disclose my child's health information for the purposes of treatment, payment, quality assurance, outcomes assessment, competence or qualifications review of healthcare professional, accreditation, licensing or credentialing activities, health plan claims or health care record analysis, provider clinical performance evaluations, utilization management, required audits or qualified healthcare operations. **I understand further that my child's records may contain entries or information relating to sexually transmitted diseases, including human immunodeficiency virus (HIV) or psychological impairment, drug and alcohol abuse and other personal information and I specifically authorize the release of such information.**

3. FINANCIAL AGREEMENT AND PAYMENT PROVISIONS
I will be billed by Dr. Needels for her services. I understand that prior to receiving services I may choose to pay for services directly if I do not want my health insurance information for that service provided to the insurance company. I further understand and agree to be liable for the full payment of the cost of service rendered to my child and will make full payment within 30 days of the bill. I understand Dr. Needels may release information to my health care insurer and it's representatives. Should the charges not be paid and account is referred to an attorney for collection, reasonable attorney's fees and collection expenses will be added to the charges. **A flat fee of $50.00 will be assessed for all no shows or cancellations less than 24 hours, for each visit.**

4 ASSIGNMENT OF INSRUANCE BENEFITS
I authorize assignment of any mental health benefits I am due to Dr. Needels for application to my bill. I further authorize Dr. Needels to accept such insurance payments. I agree to remain responsible and liable for payments of all amounts due to Dr. Needels and not received by the insurance carrier(s). I understand that Dr. Needels is rendering me a courtesy in submitting claims on my behalf. In the event that the insurance carrier rejects claims OR pays for services but later rescinds payment, I understand that I am liable for full payment of services.

5. E-MAILS, CELL PHONES, COMPUTERS AND FAXES: It is important to be aware that computers, e-mails and cell phone communication can be accessed by unauthorized people which can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to such unauthorized access as servers have unlimited and direct access to all emails that go through them. Additionally, Dr. Needels e-mails and data on her computers are not encrypted. It is always possible that faxes can be sent erroneously to the wrong address and computers, including laptops, may be stolen. Dr. Needels computers are equipped with firewall, virus protection and passwords, and she also backs up all confidential information from her computers on to CD's on a regular basis. Please notify Dr. Needels if you decide to avoid or limit, in any way, the use of e-mails, cell phones or faxes, or storage of confidential information on computers. If you communicate confidential or private information via e-mail, Dr. Needels will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and she will honor your desire to communicate on such matters via e-mail. Please do not use e-mail or faxes for emergencies. Due to computer network problems, e-mails may not be deliverable, and Dr. Needels may not check her emails or faxes daily.

My signature below will confirm I have read and agreed to the terms of this authorization for treatment for my child and that I acknowledge that I have received the HIPAA notice of policies and practices to protect the privacy of my child's health information.

THE UNDERSIGNED CERTIFIES THAT YOU UNDERSTAND THE FOREGOING AND ARE AUTHORIZED TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

_____
SIGNATURE OF PARENT, NEXT OF KIN, AUTHORIZED REPRESENTIVE OR OTHER RESPONSIBLE PARTY:

_____ _____
DATE OF SIGNATURE RELATIONSHIP TO PATIENT

COPY AS VALID AS ORIGINAL

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Parent Counseling Agreement

The goal of parent counseling is to have the parents arrive at mutually agreed decisions regarding the best ways to parent their children. This requires an environment that would allow open and honest communication between parents. An important component of that environment is confidentiality regarding the discussions and the counseling process. As such, I agree that I will hold all discussions that occur in the counseling sessions as confidential. I further agree that neither my/our counseling records nor the parent counselor will be subpoenaed in any part of our divorce/paternity or custody case.

Any agreements that we jointly make as parents may be shared with the court and others. Whatever agreements we make as parents will be put in writing by either or both of us and will be signed by both of us to demonstrate the mutuality of the decision.

Father	Date	Mother	Date