Maddisen Espeseth, PsyD, RPT, RSP • Licensed Clinical Psychologist (License Number: PSY32949)
136 South Imperial Highway, Anaheim Hills, CA 92807 • 714-790-4066 • www.drmaddisenespeseth.com

Informed Consent for Psychotherapeutic Services for Child Clients

Child (Client) Name:

Today's Date:

This form contains information about the provision of psychotherapeutic services. As a licensed psychologist, I am responsible for adhering to the law and ethical guidelines of various governing bodies including the State of California, the California Board of Psychology, the American Psychological Association, the Association for Play Therapy, and Sandplay Therapists of America. By signing your initials and signature in the designated areas below, you are confirming your understanding and agreement to the provided information.

Professional Background

I am a licensed psychologist under the California Board of Psychology (license number: PSY32949). The acronym listed behind my name, "PsyD," means that I hold a Doctor of Psychology degree. I concentrated in Child and Adolescent Clinical Psychology during my doctoral studies. Additionally, I have a Master of Arts degree in Clinical Psychology (with an emphasis in Child and Adolescent Clinical Psychology) and a Bachelor of Science degree in Health Science.

I am a Registered Play Therapist (RPT), Registered Sandplay Practitioner (RSP), and Certified Internal Family Systems (IFS) Therapist. I am also Phase One trained in the Neurosequential Model of Therapeutics (NMT), certified in Functional Family Therapy (FFT), and Level One trained in Theraplay and Marschak Interaction Method (MIM). Additionally, I am in the midst of completing the necessary requirements toward attaining future certification as a Certified Sandplay Therapist (CST); these requisites include ongoing clinical application, consultation, and clinical paper-writing.

My treatment approach is informed by attachment theory, relational psychoanalysis, Jungian/depth psychology, NMT, and IFS. I strongly value the use of play therapy and nonverbal modalities such as Sandplay, expressive arts, and sensorimotor interventions.

_____(please initial)

Right to Privacy

Your child is entitled to privacy in seeking psychotherapeutic services per the United States Constitution, California Constitution, and California Civil Code. This means that by law, I cannot divulge information regarding your child's treatment (including his/her role as my client) without your written consent. Some exceptions to privacy are included below. Please see the "Privacy Policy" subsection of the "Notice of Privacy Practices" for an extensive list and explanations of exceptions to privacy.

- Child, Elder, or Dependent Adult Abuse or Neglect

- Danger to Self or Others
- Court Order
- Unpaid Services
- Electronic Payment Processing

_____(please initial)

Coordination of Care

There may be times in which it is helpful for me to collaborate with individuals outside of my immediate relationship with you and your child (for instance, a psychiatrist, physician, academic team, other family members, etc.). In these situations, I will consult with you about the appropriateness of such coordination of care, and with your agreement, gain written consent to involve outside individuals. If collaborating with a third party, I only disclose information **directly relevant and limited** to the rationale for coordination of care (which again, you and I determine together beforehand).

_____(please initial)

Benefits and Risks

The overarching intent of psychotherapy is to assist clients with improving overall functioning. However, as treatment progresses, symptoms may actually intensify due to increased insight and understanding of oneself or others. As such, dips in functioning (such as exacerbated moodiness, argumentativeness, sleep disturbance, etc.) are to be expected. It is often true that clients feel worse before feeling better since insight tends to precede ability to cope with such awareness and effectively integrate it into everyday life. Treatment progress may therefore, be conceptualized as coil or spiral-like in nature (as opposed to linear) given that each gain in self-understanding can reveal a previously unknown or latent source of distress; thus, the process of psychotherapy may feel quite daunting at times particularly when seeking longer-term treatment.

Simply put, psychotherapy can involve a number of ups and downs depending on the intensity of symptoms and factors related to change. I am dedicated to continuously navigating these ups and downs with you and your child, and am earnest about having ongoing open communication. As such, please inform me of any concerns you and your child may have regarding symptom intensification or development of novel symptoms. Ideally, you and I can collaboratively work through such concerns. However, please know that you always have the right to refuse or cease services at any point, and seek alternative treatment elsewhere. Progress is not guaranteed.

_____(please initial)

My Treatment Approach

My intent as a psychotherapist is not to rid symptoms but instead, to assist clients in identifying the origin of, developing a relationship with, and ideally, befriending their sources of pain. I am not a skills-based therapist and do not adhere to a structured, manualized approach. My approach is relationally-focused and as such, typically takes time due to the fluid and often, ambiguous nature of relationships. Developing trust within oneself and learning to accept, foster curiosity toward, and approach pain (instead of despising or avoiding it) is not an overnight process. As noted in the "Risks and Benefits" subsection above, progress tends to be coil or spiral-like, not linear. Some also refer to treatment as a circumambulation or deepening of holistically knowing oneself (both the good and bad).

Because psychotherapy is an in-vivo process and thereby, maps onto real life, there are inevitably times in which therapy seems to be working and all of a sudden, something distressing occurs (such as unforeseen exposure to a trauma reminder). Many feel like they are back at square one when such incidences occur. My belief is that every struggle or treatment hiccup represents an opportunity or calling to better know oneself and/or others in a deeper and more complex fashion. Pain is meaningful and if we can relate to it, we can learn from it.

Change takes patience, and there is no preset or predetermined timeline for any one client. Every client is different and the time it takes to develop a secure internal attachment within oneself therefore, varies. If the speed of treatment is displeasing or concerning to you and/or your child, please inform me and we will attempt to collaboratively create psychological space for patience and self-compassion. If my approach is not congruent with you and/or your child's personal treatment goals or values, you have the right to seek treatment elsewhere at any time as similarly noted above.

_____(please initial)

Attendance and Cancellation Policy

Sessions are held at the same time and day per week when possible. Consistent attendance is imperative to treatment gains. Should your child struggle to maintain consistent attendance, you and I can consult about your child's readiness or the appropriateness of treatment at this time.

With regard to session frequency, I may advise a treatment plan involving one session alone with you (the caregiver) **and** one session either alone with your child or with the family per week (resulting in two total sessions per week). The intent of meeting with you alone is not to provide you with individual therapy as my client (since your child is my client), but to recruit your assistance in strengthening the parent-child relationship in order to facilitate your child's growth in treatment.

If clinically indicated based on the severity of your child's symptoms, I will collaborate with you in determining increased session frequency. Near the close of treatment (as symptoms reduce and functioning improves), we may decide to wean down to one session per two to three weeks in order to test out and confirm your child's readiness to officially end services.

If you and/or your child are unable to attend session, please inform me at least 48 hours prior to the appointment to cancel. **If you do not inform me of a cancellation at least 48 hours prior to the appointment (for instance, you contact me the day before or day of your session), the full session fee will still be charged**. The only exception to this cancellation policy is a psychiatric or medical emergency involving hospitalization.

If your child intends on going on vacation, has a scheduled holiday (such as Martin Luther King Junior Day) in which he/she will not be attending therapy, or is planning to take a hiatus from therapy, please inform me as soon as possible. The earlier that you inform me of planned absences, the better I can manage my schedule to try and accommodate other clients in need of services. I will similarly inform you at least two weeks prior to a vacation or planned absence on my part when possible.

If you and/or your child are late to session, we will still end at the expected time and the full service fee will be charged. Should you and/or your child chronically appear to sessions late, you and I will consult about potentially rescheduling you and/or your child's repeating appointment at a different time or date. We may also discuss readiness or the appropriateness of treatment at this time depending on the number of late sessions.

_____(please initial)

Professional Records

I am required by law to maintain treatment records. I keep these files electronically and physically stored in a manner compliant with HIPAA federal law. Please see the form, "Notice of Privacy Practices," for more information pertaining to record keeping.

_____(please initial)

Therapist Availability

Please feel free to leave a message at any time on my voicemail. When leaving a message, please include your contact information so that I may return your call at a faster rate. If I am working (and not off due to personal reasons or vacation), non-urgent phone calls will be returned within three business days. **I do not text message or email.**

If your child is experiencing a potentially life-threatening emergency, first and foremost, please contact 911 or proceed to the nearest emergency room. You are welcome to contact me secondarily once the life-threat has been stabilized. For instance,

if your child is actively suicidal, call 911 first. Once assessed by county or hospital staff, and/or hospitalized, please then, contact me.

_____(please initial)

Unexpected Therapist Absences

I am ethically and professionally-bound to ensure that your child has access to competent care in the event of an unexpected absence on my part due to sickness, accidents, significant family emergencies, etc. Should I be unable to provide services to your child due to such unforeseen circumstances, my colleague, Kylie Han Le, PsyD, licensed psychologist, will be available to assist you. I will provide her with your contact information so that she may either provide psychotherapy or offer referrals to other practitioners.

_____(please initial)

Treatment of Children of Separated or Divorced Parents

If your child is a child of separated or divorced parents, please provide me with the most updated copy of the legal decree that outlines custody arrangements. The parent that initiates treatment must have sole or joint legal custody of the child.

If custody is split, both parents must consent to treatment. If both parents are not present during the first appointment, treatment will not proceed until the absent parent has met with me and consented to treatment. Each parent will also be offered equal time with me regardless of which parent initiates treatment. Information provided by one parent may be shared with the other in order to facilitate the treatment of your child. **Exceptions to dual parental involvement include parents who live out of state, are incarcerated, pose a safety risk, or have a restraining order in place against him/her**.

I am not a custody evaluator or forensic psychologist. As such, I do **not** make recommendations regarding visitation or custody given that such advice is beyond my scope of practice. For this reason, I will **not** communicate with attorneys for either parent.

_____(please initial)

Grievances and Questions

As previously noted, I earnestly invite open communication; please inform me of any concerns you or your child may have over the course of treatment. You always have the right to contact the Board of Psychology should you have any questions or complaints regarding the practice of psychotherapy.

Board of Psychology
1625 North Market Boulevard, Suite N-215
Sacramento, CA 95834
866) 503-3221
www.psychboard.ca.gov
bopmail@dca.ca.gov

_____(please initial)

Boundaries of Competence

I am ethically required to practice within the boundaries of my competence. If I am unfamiliar with a factor related to your child's receipt of psychotherapeutic services (such as culture, religion, sexual orientation, etc.), I am obligated to seek relevant training, supervision, or consultation. Otherwise, it is my ethical duty to provide appropriate referrals and discharge in non-emergency situations.

If my personal beliefs and issues interfere with your child's treatment, you and/or your child feel uncomfortable with me, or I lack competence in treating your child's mental health concerns, I will provide you with appropriate referrals and discharge in the context of non-emergency situations.

If it is reasonably clear that your child is no longer in need of, is not benefiting from, or is being harmed by psychotherapeutic services, I am ethically obligated to provide pretermination therapy and discharge. Should your child or someone in relation to your child ever threaten or endanger my well-being, it is also considered ethically permissible for me to terminate services.

Please see the following competency limitations.

- Case Manager
  Although I provide consultative coordination of care, this service is in adjunct (and secondary) to psychotherapy. I am not a case manager.
- Forensic Psychologist or Custody Evaluator
  I am not a forensic psychologist and therefore, do not provide custody evaluations or recommendations pertaining to custody arrangements.
- Drug Counselor
  I similarly, am not a drug counselor and thus, do not treat drug or alcohol addiction. If your child is struggling with severe drug or alcohol addiction, I will discharge and refer him/her out for rehabilitation services.
- Autism Spectrum Disorder (ASD) and Attention-Deficit/Hyperactivity Disorder (ADHD)
  I do not specialize in ASD or ADHD, and am not trained in applied behavior analysis (ABA).
- Cognitive or Behavioral Therapy
  Although I treat clients with Obsessive-Compulsive Disorder (OCD), I do not practice from a singularly behavioral, cognitive-

behavioral, or Exposure and Response Prevention (ERP) lens; I utilize elements of ERP in conjunction with other models that invest greater attention to long-term intrapsychic change (such as Internal Family Systems) when treating individuals with OCD.

- Crisis Counseling

  I am also not a crisis counselor, and have specified working hours that I am available as outlined under the subsection, "Therapist Availability" of this form.
- Martial or Couples Therapy

  I do not provide marital or couples therapy or counseling.
- Psychoanalyst or Jungian Analyst

  Although my approach is informed by both relational/interpersonal psychoanalysis and Jungian psychology, I am not a psychoanalyst or Jungian analyst.

_____(please initial)

Confidentiality

"Confidentiality" refers to a client's right to communication bound by the professional relationship between client and therapist. As a licensed psychologist, I am obligated to maintain confidentiality for both legal and ethical reasons. Therefore, I do not have the right to share personal, **non**-life-threatening information that your child may privately disclose to me, such as drug or alcohol non-addictive experimentation, legally non-abusive sexual behavior, sexual or gender identity concerns, non-suicidal self-harm that does not pose an eminent physical danger, truancy, or delinquency.

However, should your child allegedly experience any form of abuse or neglect, pose danger to his/herself or others, or be at risk of immediate physical harm, confidentiality no longer applies (as outlined above in "Right to Privacy"), and I am therefore, mandated to coordinate care with the necessary entities. If your child is abusing substances and appears to demonstrate a severe addiction, I will refer him/her out for drug rehabilitation services, and discharge given that drug counseling is beyond my scope of practice.

Maintenance of your child's confidentiality may understandably, lead to uneasiness on your part. Ideally, if your child is engaging in risky behaviors, he/she and I can navigate how to effectively involve you in the reduction of such behaviors. Please know that I am legally, ethically, and morally obligated to uphold your child's safety as a priority. I welcome you to ask questions or share any concerns regarding your child's right to confidentiality.

_____(please initial)

Food in Session

I periodically have snacks (crackers, cookies, juice boxes, etc.) available in my office that I may offer to clients as part of a psychotherapeutic exercise (such as a mindfulness or parent-child bonding activity). Do I have your permission to offer your child snacks during session (please circle)?

Yes No

If yes, please list any dietary restrictions, food sensitivities, or allergies your child may have: _____

If you are allowing me to offer your child snacks in session, please inform me of any future dietary restrictions, food sensitivities, or allergies that may develop aside from those noted above.

_____(please initial)

Drug and Alcohol Use

If your child appears to session under the influence of drugs or alcohol, the appointment will be prematurely terminated. Unfortunately, I will also charge the full session fee given that the appointment was not cancelled by you beforehand (please see the "Attendance and Cancellation Policy" section of this document).
Psychotherapy is not effective if a client is intoxicated in session. I am also not a drug counselor. If your child appears to session intoxicated on multiple occasions, I will refer him/her out for drug rehabilitation services, and discharge given that drug counseling is beyond my scope of practice.

_____(please initial)

Corona Virus

You understand that by meeting face-to-face, you are assuming the risk of exposure to COVID-19 for you and your child. Should there be a resurgence of COVID-19, you and I will determine the format and course of treatment, which may involve use of telehealth (likely Zoom videoconferencing). When meeting in-person, you are agreeing to comply with the following precautions:

- If you and/or your child have tested positive for COVID-19 in the last fourteen days, you will **immediately** inform me and cancel your in-person appointment.
- If you and/or your child have been experiencing COVID-19 symptoms (such as fever, shortness of breath, etc.) in the last fourteen days, you will cancel your in-person appointment.
- If you and/or your child have been in contact with someone with COVID-19 or have traveled in the last fourteen days, you will cancel your in-person appointment.

- You and your child will follow social distancing and mask-wearing recommendations as needed.
- You and your child will follow self-hygiene recommendations (such as regular hand washing, avoidance of touching face or eyes with dirty hands, etc.).

If you or your child have tested positive for COVID-19 or are actively demonstrating symptoms in the last fourteen days, and still come in for a face-to-face appointment, I will require you and/or your child to leave the office immediately. I will also unfortunately, charge the full session fee since you did not cancel beforehand (please see the "Attendance and Cancellation Policy" section of this document).

However, if you or your child happen to contract COVID-19 less than 48 hours prior to session and you **immediately** call me to cancel, we will reschedule the appointment and I will not charge you. Basically, please stay home if you or your child test positive or are demonstrating symptoms.

_____(please initial)

Accommodations

My office is located on the second floor of 136 South Imperial Highway, Anaheim, CA 92807. Unfortunately, the business building does not have an elevator. If you and/or your child are unable to walk upstairs, please inform me and we will collaborate in identifying a suitable meeting place other than my office.

_____(please initial)

By initialing below, you are confirming that you have been provided the opportunity to ask questions. This authorization remains in effect until revoked by you.

_____(please initial)

Your signature below denotes that you have read, understand, and agree with all of the information provided above. Your signature indicates your consent to proceed with treatment.

Parent/Legal Guardian Signature	Printed Name	Date

Client Signature	Printed Name	Date

Maddisen Espeseth, PsyD		Date

Notice of Privacy Practices for Child Clients

Child (Client) Name:

Today's Date:

I am legally and ethically obligated to maintain a treatment record of care and services provided to clients. The following is written in accordance with Health Insurance Portability and Accountability Act (HIPAA) federal law in conjunction with the United States Constitution, California state law, and the American Psychological Association ethical guidelines. This form explains how your protected health information (PHI) can be utilized or disclosed. ("Protected health information" refers to information pertaining to a client's mental health condition, provision of services, and payments.) This form also includes information about how to access your PHI. Please review the following carefully.

Client Privacy-Related Rights

- Right of Notice
  You are to be provided with a written and electronic copy of this form ("Notice of Privacy Practices"). Should you like another copy at any point in the future, please inform me and I will provide one accordingly.
- Right to Request Restrictions
  You and your child have the right to request restrictions to the use and disclosure of PHI. I am obligated to meet these requests when considered reasonable.
- Right to Receive Confidential Communications
  You have the right to request that bills be mailed to an address other than your home address. You may also request that I not contact your home phone.
- Right to Access Records
  California law requires that treatment records be maintained over the entire extent of active treatment in addition to at least seven years from the date a minor turns 18-years-old. Per the American Psychological Association record-keeping standards, records must be maintained for seven years past the last date of service delivery, or three years after the minor reaches the age of the majority (whichever is later). According to California law, you have the right to inspect treatment records within five days after I receive a written request from you. I must provide you with copies of treatment records within fifteen days after I have received a written request from you per California law. Records cannot be withheld due to unpaid bills per California law. I charge $0.20 per page when providing copies. HIPAA denotes that clients do **not** have the right to inspect or obtain copies of psychotherapy notes. California law permits me to offer you a treatment summary, which is to be completed within ten days of the offer being accepted by you. Should extenuating circumstances exist, you will be informed and the summary will be delivered within

thirty days. **Access to records can be denied if your child is legally authorized to obtain treatment by his or herself, or if I determine that access may result in adverse or detrimental effects on the client-therapist relationship or your child's physical/emotional well-being**. If a court order mandates the release of records, or you provide written consent to authorize the release of records to the California Board of Psychology, I will provide records within fifteen days.

- Right of Amendment

  You have the right to request amendments to PHI. This request can be denied if I determine that the alteration would make the PHI less accurate. Regardless, a record can never be expunged.

- Right of Accounting

  You have the right to receive a list of all PHI disclosures within the past six years. This list must include information pertaining to the date of disclosure, whom the information was disclosed to, and a description of what information was disclosed as well as the rationale. Your written authorization may be utilized instead of such accounting procedure.

- Right to Revoke Written Authorizations

  You have the right to revoke written authorizations at anytime. The authorization will cease to be effective on the date of notification except to the extent action has already been taken in reliance upon it. The revocation will be honored unless contact with a third party is considered an exception to privacy or privilege (such as child abuse, danger to self or other, etc.).

- Right to Hold Privilege

  "Privilege" refers to a client's right to maintain confidential communications from being disclosed in a legal proceeding. A client is typically the holder of privilege, and may therefore, claim privilege during legal proceedings. However, if a client lacks legal capacity (such as a non-emancipated or non-self-sufficient minor), the guardian or conservator is the holder of privilege. In the event that a client dies, the client's personal representative is the holder of privilege. Regardless of who may be the holder of privilege, he/she has the right to authorize any person to similarly claim privilege. .

- Minor Welfare

  I am ethically and legally obligated to protect your child's rights and welfare even when consent from a legal guardian is not mandated (such as child abuse reporting) or not permitted by law (such as with emancipated minors).

- Minor Right to Consent to Treatment

  Your child is legally allowed to seek out and receive outpatient mental health services without parental consent if he/she is at least 12-years-old and mature enough to participate in treatment according to the Health and Safety Code. You should be included in treatment unless your involvement is considered inappropriate (due to considerations such as client safety) per the Family Code, and Health and Safety Code. In the

event that your child is 12 years of age or older and is seeking services related to his/her alleged rape, I am not permitted to inform you. You are not responsible for service payments unless you have consented and/or participated in treatment.

- Emancipated Minor Rights

  If your child is an emancipated minor, he/she is treated as an adult with regard to confidentiality, privilege, and consent to treatment.

- Right to File a Complaint

  You and your child have the right to contact the California Board of Psychology at anytime to ask questions or file grievances.

Board of Psychology
1625 North Market Boulevard, Suite N-215
Sacramento, CA 95834
866) 503-3221
www.psychboard.ca.gov
bopmail@dca.ca.gov

Privacy Policy

Your child is entitled to privacy in seeking psychotherapeutic services per the United States Constitution, California Constitution, and California Civil Code. This means that by law, I cannot divulge information regarding your child's treatment (including his/her role as my client) without your written consent. Some exceptions to privacy include:

- Child, Elder, or Dependent Adult Abuse or Neglect

  I am a mandated reporter and am therefore, required by law, to report child abuse or neglect to a county welfare department (like Orange County Child Protective Services) or a peace officer. I am similarly mandated to report elder or dependent adult abuse or neglect to a county welfare department (like Orange County Adult Protective Services), law enforcement, a local ombudsman, or a state investigator depending on the adult's place of residency. I am ethically obligated to keep your child's privacy a priority even when filing a report; this means that when filing a report, I only disclose information **directly relevant and limited** to the abuse or neglect and completion of the report. Should I need to file a report, I will attempt to involve you in the process when possible.

- Danger to Self or Others

  I am a mandated reporter and am therefore, required by law, to report to a peace officer, mobile crisis team member, or county-designated professional when a client is considered a danger to his/her self or others. I am ethically obligated to keep your child's privacy a priority even when filing a report; this means that when filing a report, I only disclose information **directly relevant and limited** to the eminent danger to your child or others, and completion of the report. Should I need to file a report, I will attempt to involve you in the process when possible.

- Treatment Emergencies

  If your child is involved in a situation that puts him/her at risk of immediate physical harm and I am contacted by his/her treating health care provider, I am obligated to disclose information in order to ensure your child's safety. For instance, if your child is hospitalized for psychiatric reasons and I am contacted by a hospital staff member, I will only disclose information **directly relevant and limited** to your child's immediate care (such as my role as your child's therapist, session attendance consistency, etc.). I am ethically obligated to keep your privacy a priority even when coordinating care. When possible, I will inform you of this coordination of care and involve you in the process.
- Court Order

  If ordered by a court to release records (as with a subpoena), I am legally obligated to respond. If I am required to appear in court, I will assert privilege on your child's behalf. ("Privilege" refers to a client's right to maintain confidential communications from being disclosed in a legal proceeding.) However, should the judge determine that the requested information is an exception to privilege, I must comply with the court order and release the required information. In extreme circumstances, this may involve disclosure of your child's entire clinical record.
- Civil or Criminal Wrongdoing

  Privilege no longer exists should a client seek psychotherapeutic services to assist with committing a crime, or avoiding detection or apprehension of an already committed crime. I am obligated to contact law enforcement in such situations.
- Unpaid Services

  If you have an unpaid balance for services rendered, I will first attempt to contact you to ideally, resolve the issue with you directly. However, if you are unresponsive to these efforts, I will utilize the services of a collection agency. I am ethically obligated to keep your child's privacy a priority when contacting a collection agency; this means that I only disclose information **directly relevant and limited** to unpaid services (such as your name, balance owed, etc.).
- Electronic Communications

  Please be aware that cell phone and telehealth communications can be intercepted and that confidentiality is therefore, not guaranteed. **I do not text message or email** given that both forms of communication can be easily hacked (and therefore, pose risks to your child's privacy). I similarly do not interact with clients via social media.
- Electronic Payment Processing

  If paying electronically, I utilize Ivy Pay, a Health Insurance Portability and Accountability Act (HIPAA)-compliant payment app. Charges will appear on the payer's card statement as "Ivy Session Payment" for services rendered by MDE Psychological Services, Inc.

- Consultation and Supervision
  I am ethically obligated to seek consultation and supervision as necessary per a client's treatment needs. I am also personally in the midst of a number of certifications that similarly require professional consultation and supervision. When consulting or seeking supervision, I only disclose information **directly relevant and limited** to the consultation or supervision needs.
- Quality of Care Review
  Per California law, confidential information can be disclosed without your consent for the purpose of quality of care review (such as audits or investigations). If a professional standards review organization requires a review of my competence, qualifications, or health care services, your child's PHI may be disclosed according to the California Civil Code.
- Crimes Involving a Hospitalized Patient
  Per the Welfare and Institutions Code, I am obligated to report to law enforcement if your child is hospitalized and has committed a serious crime (such as murder). I am similarly mandated to report to law enforcement if your child is hospitalized and has been victim to a serious crime (such as rape). I only disclose information **directly relevant and limited** to the crime involvement and completion of the report.
- Mental or Emotional Health-Related Legal Claims
  If your child claims mental or emotional suffering in a legal proceeding, privilege no longer exists.
- Legal Dispute Involving a Deceased Person
  Privilege does not exist if PHI is needed to settle a legal dispute involving a deceased client's interests, deed, or will.
- Malpractice Suit
  If you initiate a malpractice suit against me, privilege no longer exists. Legally, I have the right to utilize treatment records to defend myself.
- Health Insurance
  If you are paying via private health insurance, I may need to disclose treatment information (such as diagnosis, services rendered, etc.) in order to ensure coverage. I am ethically obligated to keep your child's privacy a priority even when coordinating care with an insurance panel; this means that when consulting, I only disclose information **directly relevant and limited** to the coverage issue at hand.

Written Authorization

There may be times in which it is helpful for me to collaborate with individuals outside of my immediate relationship with you and your child (for instance, a psychiatrist, physician, academic team, other family members, etc.). In these situations, I will consult with you about the appropriateness of such coordination of care, and with your agreement, gain written consent to involve outside individuals. If collaborating with a third party, I only disclose information **directly relevant and limited** to the rationale for coordination of care (which again, you and I determine together beforehand).

My Responsibilities

I am obligated by state and federal law to maintain the privacy and security of your child's PHI. Information pertaining to my privacy policy is listed above. With regard to the security of your child's PHI, I am required by HIPAA to lock physical treatment documents in an office filing cabinet, safeguard electronic records with passwords and firewalls, and encrypt emails that involve PHI. In the event that a breach occurs that compromises the privacy or security of your child's PHI, I will immediately inform you and take necessary measures on my part to attempt to resolve the situation.

I will never use or disclose your child's PHI for marketing purposes. Similarly, it is illegal for me to sell your child's PHI in the regular course of business.

I am legally and ethically required to follow the terms of this notice that is currently in effect as of November 1st, 2021. Should the terms of this notice change in the future, the update will apply to all PHI in your child's record, and a revised notice will be provided to you.

For further information pertaining to the HIPAA Privacy Rule, please defer to:

United States Department of Health and Human Services: Office for Civil Rights
200 Independence Avenue
Washington, D.C. 20201
800) 368-1019
www.hhs.gov
OCRMail@hhs.gov

By signing below, you are confirming that you have read, understood, and agree with the information included in this form.

Parent/Legal Guardian Signature	Printed Name	Date

Client Signature	Printed Name	Date

Maddisen Espeseth, PsyD		Date

Acknowledgement of Receipt of Notice of Privacy Practices for Child Clients

Child (Client) Name:

Today's Date:

You child is entitled to certain rights pertaining to the use and disclosure of his/her protected health information (PHI) as outlined by the Health Insurance Portability and Accountability Act (HIPAA). By signing below, you are acknowledging and confirming your receipt of a "Notice of Privacy Practices" form. Please feel free to request another copy of the "Notice of Privacy Practices" form at anytime in the future. For further information pertaining to the HIPAA Privacy Rule, please defer to:

United States Department of Health and Human Services: Office for Civil Rights
200 Independence Avenue
Washington, D.C. 20201
800) 368-1019
www.hhs.gov
OCRMail@hhs.gov

Parent/Legal Guardian Signature	Printed Name	Date

Client Signature	Printed Name	Date

Maddisen Espeseth, PsyD		Date

Safety Agreement for Child Clients

Child (Client) Name:

Today's Date:

In the event that your child is experiencing suicidal ideation, homicidal ideation, or symptoms (such as command hallucinations or severe self-harm) that endanger the life or physical safety of your child or another, please call 911 or proceed to the closest emergency room. You are welcome to contact me secondarily once the life-threat has been stabilized.

Please see below for a list of safety and crisis-related resources:

- National Suicide Prevention Lifeline (24-7 Availability; Call)
  800-273-8255 (English and Spanish Crisis Counselors)
  877-727-4747 (Korean Crisis Counselors)
  877-272-4747 (Request Multilanguage Line for Other Language Crisis Counselors)
- Orange County Warmline (24-7 Availability; **Text** or Call)
  714-991-6412 (English Crisis Counselors)
- Didi Hirsch Suicide Prevention (24-7 Availability; **Text**)
  839863 (Text: "HEARME") (English Crisis Counselors)
- Orange County Centralized Assessment Team (24-7 Availability; Call)
  866-830-6011 (English, Spanish, Vietnamese, Korean, Cambodian, and Arabic Crisis Evaluators)
- California Youth Crisis Line (24-7 Availability; Call)
  800-843-5200 (English and Multilanguage Crisis Counselors)
- Teen Line (Monday-Friday 6 PM-10 PM Availability; Call)
  1-800-852-8336 (English Peer-to-Peer Support by Teen Crisis Trainees)
- Lifeline Crisis Chat (24-7 Availability; Web Chat)
  didihirsch.org/chat/ (Click Link: "Click here to be linked to Lifeline Crisis Chat") (English Crisis Counselors)

By signing below, you are confirming that you have read, understood, and agree with the information included in this form.

Parent/Legal Guardian Signature	Printed Name	Date

Client Signature	Printed Name	Date

Maddisen Espeseth, PsyD		Date

Payment Information for Child Clients

Child (Client) Name:

Child (Client) Date of Birth:

Today's Date:

Intake (First Billed Service) Date:

Name of Insurance:

Fees for Services

Fees for psychotherapeutic services are due at the beginning of the appointment time. Please note that the following fees may be subject to change. **Payment via cash or check can result in a $5 discount per service rendered as listed below.**

- Intake (Clinical Interviews/Parent-Child Play Observation)
  $190 per 50 minute session (Credit Card)
  $185 per 50 minute session (Cash or Check)
- Individual or Family Psychotherapy
  $190 per 50 minute session (Credit Card)
  $185 per 50 minute session (Cash or Check)
- Coordination of Care/Consultation Services
  $190 per hour (Credit Card)
  $185 per hour (Cash or Check)
- Classroom Observation
  $145 per hour (Credit Card)
  $140 per hour (Cash or Check)
- Non-Court Related Documentation Preparation (Letters, Summaries, Etc.)
  $170 per hour (Credit Card)
  $165 per hour (Cash or Check)
- Participation in Court Related Activities (Phone Consultations, Written Material Preparation, Responding to Court Orders, Etc.)
  $500 per hour
- Court Appearance
  $3,000 per day

If the provision of a service involves driving off-site from my office, travel time beyond 15 minutes is added to the final charge at the proportionate hourly rate.

No Surprises and Good Faith Estimate Acts

You are protected from surprise billing under the No Surprises Act if paying via insurance. You are never required to receive out-of-network services and have the right to seek alternative mental health services outside of this practice and within your insurance

network should you see fit. Seeking mental health services with me is completely voluntary on your part.

When paying for services out-of-pocket, you have the right to receive a good faith estimate outlining the anticipated cost of care. A good faith estimate is not a contract and does not require you to obtain the services listed in the estimate. This initial estimate does not include unknown or unexpected costs that may arise during treatment which means that you could be charged more if complications or special circumstances occur; however, you will be informed of all charges before billed. (No charges will occur by surprise.) You have the right to dispute a claim should you receive a bill that exceeds your good faith estimate by at least $400. I encourage you to contact me directly in order to identify a dispute resolution. Nonetheless, you have the right to contact the United States Department of Health and Human Services (HHS) if you see fit. If seeking the dispute process assistance of HHS, you must contact HHS within 120 calendar days of the original bill date and will be charged $25 by HHS. Should you seek dispute resolution with either me or HHS, your health care services will not be adversely affected.

United States Department of Health and Human Services
200 Independence Avenue
Washington, D.C. 20201
877) 696-6775
www.cms.gov/nosurprises
OCRMail@hhs.gov

Please see the following Current Procedural Terminology (CPT) service codes utilized by this practice and respective costs for cash or check payments relisted below.

- 90791 Intake (50 minutes): $185
- 90834 Psychotherapy (50 minutes): $185
- 90846 Family Psychotherapy (Without Client Present) (50 minutes): $185
- 90847 Family Psychotherapy (With Client Present) (50 minutes): $185
- 90887 Case Management (See Below; Listed Per Hour):
  Coordination of Care/Consultative Services: $185
  Classroom Observation: $140
  Documentation Preparation (Non-Legal Matters): $165
  Documentation Preparation (Legal Matters): $500

Provisional International Classification of Diseases, Tenth Edition (ICD-10) Diagnostic Code:

I am required by law to include the following identifying information as part of your good faith estimate.

- Provider Name: Maddisen Espeseth, PsyD
- National Provider Identifier (NPI): 1134592140
- Tax Identification Number (TIN): 87-3355446
- Office Location Where Services Are Expected to be Rendered: 136 South Imperial Highway, Anaheim Hills, CA 92807

Please see your good faith estimates for psychotherapy (when paying by cash or check) below:

- Weekly Therapy (1 Month): $740 ($185 X 4 Weeks)
- Weekly Therapy (6 Months): $4,810 ($185 X 26 Weeks)
- Weekly Therapy (12 Months): $9,620 ($185 X 52 Weeks)
- Biweekly (Twice a Week) Therapy (1 Month): $1,480 ($185 X 2 Sessions X 4 Weeks)
- Biweekly Therapy (6 Months): $9,620 ($185 X 2 Sessions X 26 Weeks)
- Biweekly Therapy (12 Months): $19,240 ($185 X 2 Sessions X 52 Weeks)

The above estimates are only estimates and may differ from actual costs should unexpected circumstances arise. These estimates are excluding case management services and therefore, do not reflect estimates that may involve adjunct services such as coordination of care or classroom observations. As such, separate good faith estimates may be provided should the need to include regular case management services arise. All services will be reviewed with you prior to billing; for instance, if we mutually agree that a consultation with your child's psychiatrist is warranted, I will consult with the psychiatrist then call you to review the expected cost of service based on the time spent consulting. I then bill. Transparency is one of my priorities. If you are ever uncertain regarding a bill, please inform me immediately. You always have the right to obtain a copy of your good faith estimate(s).

Attendance and Cancellation Policy

The Attendance and Cancellation Policy is outlined in full in the form, "Informed Consent for Psychotherapeutic Services for Child Clients," under the subsection, "Attendance and Cancellation Policy." As explained, the full session fee is charged if an appointment is cancelled less than 48 hours prior. As similarly outlined in "Informed Consent for Psychotherapeutic Services for Child Clients" under the "Drug and Alcohol Use" subsection, an appointment will be prematurely terminated and the full session fee will be charged if your child appears to session intoxicated. Denoted under the "Corona Virus" subsection of "Informed Consent for Psychotherapeutic Services for Child Clients," the appointment will not proceed and the full session fee will be charged, if you and/or your child come in for a face-to-face session having tested positive for COVID-19 or actively demonstrating symptoms within the last fourteen days.

Forms of Payment

As noted, fees are due at the beginning of each appointment. I accept cash, check, or card. **Payment via cash or check can result in a $5 discount per service rendered.**

- **If paying by check:**
  - Please address the check to: MDE Psychological Services, Inc.
  - Should your check bounce, an additional clerical fee of $50 will be added to the original check balance. For instance, if a $185 session check bounces, the updated charge will be $235.

- **If paying by card**:

    - If processing payments electronically, I am legally obligated to utilize a processing program that is HIPAA-compliant. I utilize the HIPAA-compliant app, Ivy Pay.

    - Ivy Pay requires that you input your card information via a text message sent through the company to process your first payment. This text also includes a digital receipt option. Your card is thereafter, privately saved on my account. I will lead you through this process during our first appointment should you choose to pay via credit or debit card. Charges on your card statement may appear as "Ivy Session Payment" for services rendered by MDE Psychological Services, Inc.

    - If a need to alter your payment form/card information arises in the future, please inform me **immediately**. Otherwise, I will assume that the provided card information is accurate and charge/collect the fee accordingly.

    - Please include your information below if paying by card:

Cardholder Name: _____

Cardholder Phone Number: _____

Card Number: _____

Expiration Date (Month and Year): _____

CVV: _____

Cardholder Billing Address: _____

Card Type (please circle):

Debit Credit Visa Mastercard American Express Discover

By signing below, the cardholder is authorizing me, Maddisen Espeseth, PsyD (MDE Psychological Services, Inc.), to charge his/her card through Ivy Pay. The cardholder also agrees that his/her card will be charged for any session that is not cancelled at least 48 hours prior to the scheduled appointment time. The cardholder understands that this authorization will remain in effect until cancelled in writing. The cardholder will inform me in writing of any changes to his/her account or termination of this authorization.

_____

Cardholder Signature Date

Billing Address

Should there be a need to provide a summary of billed services, am I permitted to send billing information to your home address (please circle)?

Yes No

If no, please include the address you would like me to send billing information to below:

_____

Superbills

As noted above, I directly bill clients the same day of service provision. Per request, I offer monthly superbills (itemized summaries of billed services provided to you through this practice) that you can submit to your insurance for possible reimbursement. I am not contracted with any insurance panels and therefore, do not directly bill any panels. It is your responsibility to submit superbills to your insurance panel as you see fit. There is no guarantee of reimbursement/coverage. You always have the right to directly contact your insurance panel to inquire if they accept out-of-network provider services/superbills in order to clarify if and how much your insurance is willing to reimburse.

Unpaid Services

Per the "Right to Privacy" subsection (specifically, "Unpaid Services") of the form, "Informed Consent for Psychotherapeutic Services," I will utilize the services of a collection agency in the event that you have an unpaid balance for services rendered **and** are unresponsive to my attempts to contact you to resolve the issue.

By signing below, you are confirming that you have read, understand, and agree with the information included in this form.

_____

Parent/Legal Guardian Signature Printed Name Date

_____

Maddisen Espeseth, PsyD Date

Video Consent for Child Clients

Child (Client) Name:

Today's Date:

I, _____(legal guardian's name) certify that I am the legal guardian of _____(child's name), and thereby, permit the use of videotaping during the provision of psychotherapeutic services by Dr. Maddisen Espeseth.

I am aware that the video recordings are to be utilized for training and teaching purposes, and will destroyed by Dr. Espeseth once no longer needed for such purposes. I have been informed that the video recordings are considered protected health information (PHI) and shall be treated as such with regard to privacy and security. Accordingly, PHI will not be shared outside of the context of professional training and teaching relationships, and the tapes will be stored in a secure location inaccessible to the public.

By signing below, you are confirming that you have read, understand, and agree with the information included in this form.

Parent/Legal Guardian Signature	Printed Name	Date

Client Signature	Printed Name	Date

Maddisen Espeseth, PsyD		Date

Sandplay Therapists of America (STA)

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____,
herby grant and authorize:

- □ Maddisen Espeseth, PsyD (Sandplay Therapist)
- □ Sandplay Therapists of America (STA)
  International Society for Sandplay Therapists (ISST)

To use all data (including photographs of sandplay images) in his/her casework with:

- □ Myself
- □ Minor Child of whom I am the parent or legally appointed guardian

For purpose of (please initial all that apply) :

_____Research
_____Presentation at professional meetings
_____Training
_____Publications
_____Electronic publication (utilizing the internet)
_____Professional consultation

I understand that I/my child will be assigned a pseudonym (a different name) by the above-named therapist to protect privacy. The last name will not be used. This pseudonym will be : _____

The present authorization will last indefinitely unless I revoke it in writing.

_____

_____
Signature Date

_____Address :_____
Printed Name

_____
Therapist / Witness Date