CHLOE ZINGARO, LCSW
AUTHORIZATION AND CONSENT
FOR MENTAL HEALTH TREATMENT OF A MINOR

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

Child/Adolescent's Name: _____

Names of parents/guardians:
Mother:_____ Father: _____

Child's Birth Date: _____ Child's Age:_____
Child's Grade level:_____ Child's School:_____
Child's Gender:_____
Home Address:
_____
_____
_____
Home Number: _____ Voice and text messages □Yes □No
Cell Number: _____ Voice and text messages □Yes □No
Work/Other: _____ Voice and text messages □Yes □No

Professionals Include: Chloe Zingaro, LCSW. Chloe is an independent practitioner.

IN CASE OF SEPARATION OR DIVORCE
In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. **If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.** If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

PSYCHOLOGICAL SERVICES
I offer a wide variety of counseling services, including individual, couples, family and group services. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. My primary theoretical perspectives include Cognitive Behavioral Therapy (CBT), Rational Emotive Behavioral Therapy (REBT),

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Dialectical Behavioral Therapy (DBT), DBT for Children (DBT-C) and DBT for Adolescents (DBT-A), DBT prolonged exposure therapy (DBT-PE), and DBT for Complex PTSD (DBT-CPTSD).

Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on you AND your child's part. In order for the therapy to be most successful, you and your child will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you and/or your child may experience uncomfortable feelings like sadness, guilt, anger, shame, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you or your child will experience.

Our first few sessions will involve an evaluation of your child's needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you and your child feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress.

Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

INDIVIDUAL PARENT/GUARDIAN COMMUNICATION WITH ME

In the course of my treatment of your child, I may meet with the child's parents/ guardians either separately or together. Please be aware, however, that, at all times, my

patient is your child – not the parents/guardians nor any siblings or other family members of the child.

If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

MANDATORY DISCLOSURES OF TREATMENT INFORMATION

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm [and the police].
- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

DISCLOSURE OF MINOR'S TREATMENT INFORMATION TO PARENTS

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate

harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

> ***Example***: If your child tells me that he/she has tried alcohol at a few parties, I would keep this information confidential. If you child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.

> ***Example***: If your child tells me that he/she is having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing _____, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

CONSENT FOR DBT CONSULTATION TEAM

For clients in DBT your information may be shared in consultation team in an effort to give you the most adherent and effective treatment possible. DBT is a team approach therefore each therapist has the support of their consultation team. Team helps increase the competence of the therapist as well as ensure the therapist is staying within the DBT framework. Dallas DBT meets weekly and consults with an outside consultant through the Linehan Institute/Behavioral Tech. I make every effort to avoid revealing information that is not pertinent to your treatment. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together. Professionals on my consultation team include: Laura Cooper, Ph.D, Julie Euseppi, LCSW, Tammy Hyde, LPC, Linda O'Toole, LPC, and Susan Shiring, LCSW. By signing this consent you agree that I may share information about you and your child with my consultation team in order to deliver the most adherent and effective treatment possible. By signing this consent, you are also agreeing to be treated by the consultation team in the event that a team member is co-leading group, substituting for me in my absence, or taking phone coaching calls during my vacations. This consent will remain in effect while you are receiving treatment from

the above providers and myself for thirty days following termination of treatment unless you provide earlier written notice of its revocation.

DISCLOSURE OF MINOR'S TREATMENT RECORDS TO PARENTS

Although the laws of Texas may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

PARENT/ GUARDIAN AGREEMENT NOT TO USE MINOR'S THERAPY INFORMATION/ RECORDS IN CUSTODY LITIGATION

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $180 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

SESSIONS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we agree to begin psychotherapy, I will usually schedule one 45-minute session per week, at a time we agree on, although some sessions may be longer or more frequent. Clients who are participating in Dialectical Behavioral Therapy (DBT) will be required to attend one 45-minute session per week and one 60-minute skills group training per week. Parents of adolescents in DBT are to attend the Parent/Caregiver Skills Group once weekly as part of the treatment model. For children in DBT-C, the session is 90 minutes once weekly (30 minutes with child, 30 minutes with parents, 30 minutes with family for DBT skills lesson). **Once an appointment hour is**

scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation. If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

$220 Individual Sessions (45 minutes)
$240 Individual Sessions (60 minutes)
$240 Couple or family sessions (60 minutes)
$240 Intake Evaluation (60 minutes)$360 90 Minute sessions (indicated for Gottman Couples, DBT-C and prolonged exposure sessions)
$80 Group Sessions (60 minutes)
$880 Cost of DBT Pretreatment sessions (Four orientation sessions prior to being accepted into DBT program)

In addition to weekly appointments, I charge an hourly rate of $180 for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. I do not charge for DBT coaching calls. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. I charge $180 per hour for professional services I am asked or required to perform in relation to your legal matter. Also if we meet more than the usual time 45-minute time frame, I will charge accordingly.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held unless we agree otherwise. Payment schedules for other professional services will be agreed to when such services are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due. **Please provide payment in the form of CASH, CHECK or CREDIT CARD. If requested, a statement of services rendered can be provided.**

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INSURANCE REIMBURSEMENTS

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. **I am an out of network provider and do not take health insurance.** If you wish to file with your insurance company in order to seek reimbursement, I will give you a receipt with diagnosis and billing codes for the times of service. You will be responsible for submitting these to your insurance and any further communication insurance might require for processing your claim.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

You should also be aware that most insurance companies require that I provide them with your child's diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit, if you request it. You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.

CONTACTING ME

I am often not immediately available by telephone. I will not answer the phone when I am with a patient. I will make every effort to return your or your child's call on the same day you make it and will respond as quickly as possible if you are a DBT client calling for coaching. At the start of treatment, clients will be given their therapist's preferred mode of contact for emergencies and coaching calls. If you are unable to reach me and feel that you cannot wait for me to return your call, dial 911 or go to the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary and make arrangements for you to see another colleague in my absence.

THERAPIST INCAPACITY OR DEATH

I understand that, in the event of death or incapacitation of the undersigned therapist, it will be necessary to assign my case to another therapist and for that therapist to have possession of my treatment records. By my signature on this form, I herby consent to another licensed mental health professional, selected by the undersigned therapist, to

take possession of my records and prove me copies at my request, and/or to deliver those records to another therapist of my choosing.

ELECTRONIC COMMUNICATIONS POLICY

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

EMAILS AND TEXTS

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Be advised that communicating clinical matters via email is not a secure way to contact to me and could put your privacy at risk. I do use a secure HIPPA compliant email platform. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

SOCIAL MEDIA

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you. I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

WEBITES

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review

the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

WEB SEARCHES

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

CONSENT TO TREATMENT OF A MINOR

We/I, the undersigned_____, parent(s) and/or guardian(s) of a minor child _____, give you, Chloe Zingaro, LCSW full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. Moreover, We/I understand that although I have a right to my child's records, I will waive my right to any records or disclosures, if, in the opinion of Chloe Zingaro, LCSW such disclosure could negatively impact my child or my child's treatment. This consent is given by me/us as parent(s) and/or guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of minor said child. It is clearly understood that Chloe Zingaro, LCSW is hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that the duties are performed with standard care and responsibility to the best of her professional ability.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____

Signature of parent/legal guardian Date

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_____ _____

Signature of parent/legal guardian Date

_____ _____

Signature of therapist Date

CREDIT CARD PAYMENT AUTHORIZATION

I,_____, hereby authorize Margaret Chloe Zingaro, LCSW, PLLC to keep my credit card information and signature on file and to automatically charge my credit card account for: confirmation of initial evaluation appointments, appointments, missed/cancelled appointments including the initial evaluation without 48 hours notice (will be charged at full fee), late fees (invoices past 30 days due), chargeback fees, and the full check(s) amount that is/are not cleared by the bank plus a $30 returned check charge per incident, and will not dispute the charges with my credit card company. This authority is to remain in full force and effect until Margaret Chloe Zingaro, LCSW, PLLC has received notification from me in writing in such time and in such manner as to afford Margaret Chloe Zingaro, LCSW, PLLC a reasonable opportunity to act on it.

Client Name: _____

Cardholder Name (as on card):_____

Credit Card Number: _____

CVV Code (3 digits):_____

Credit Card Type (please circle one): Visa / Master Card/ Discover/ Amex

Expiration Date: _____/_____/_____

Cardholder Billing Address (Street Number, Address, City, State, Zip Code) :

_____ _____

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Cardholder Phone Number: _____

Cardholder's Signature: _____ Date: ___/___/___

NOTICE OF PRIVACY PRACTICES:
RECEIPT AND ACKNOWLEDGMENT OF NOTICE

If you would like a copy of the Notice of Privacy Practices it will be provided to you at your appointment and it can also be found on my website: www.cztherapy.com

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Margaret Chloe Zingaro, LCSW, PLLC Notice of Privacy Practices. I understand that I can access the Notice of Privacy Practices on Chloe's website. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Chloe Zingaro, LCSW.

_____ _____

Signature of Patient/Client Date

_____ _____

Signature of Guardian of Patient/Client Date

AUTHORIZATION TO CONTACT BY TELEPHONE/VERBALLY IN EVENT OF BREACH OF PHI

I, _____ [Insert Name of Patient/Client], authorize Margaret Chloe Zingaro, LCSW, PLLC to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI) by Margaret Chloe Zingaro, LCSW, PLLC. Such conversation shall be documented by Margaret Chloe Zingaro, LCSW, PLLC. Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Margaret Chloe Zingaro, LCSW, PLLC.

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_____ _____

Please read the following and initial each statement indicating your understanding of and agreement with its contents and implications. Chloe Zingaro, LCSW is unable to provide treatment without these terms being agreed upon in advance.

_____ I understand that I will be paying the following fees for clinical services:

_____ $220 Individual Sessions (45 minutes)
_____ $240 Individual Sessions (60 minutes)
_____ $240 Couple or family sessions (60 minutes)
_____ $240 Intake Evaluation (60 minutes)
_____ $360 90 Minute sessions (indicated for Gottman Couples, DBT-C and prolonged exposure sessions)
_____ $80 Group Sessions (60 minutes)
_____ $880 Cost of DBT Pretreatment sessions (Four orientation sessions prior to being accepted into DBT program)
_____ Other $_____

____ You will be charged for 15 minute increments for additional time on sessions, telephone consultations, case management, document review, and e-mail correspondence (excluding appointment scheduling). These charges will be automatically charged to the active credit card on file.

___ This office does not carry balances. We will be happy to provide you with receipts for you to submit to your insurance at your request. These forms are generated monthly but can be provided at other times per your request. Please email to request a receipt or ask at the end of your session.

___ I understand that I am responsible for payment of any missed session unless I have provided a minimum of 48 hours in advance of the appointment. Cancellations must occur by phone call or text to 214-966-0040.

___ I understand that I will forfeit my session if I am 15 minutes late without notification to Chloe Zingaro, LCSW. If Chloe has not received notification by me within 15 minutes that I am arriving late, she will bill me for the session and the session will be forfeited.

___ I have received a copy of the Texas Notice Form that explains the use and disclosure of my mental health record maintained by this office. A copy of the Texas Notice Form can be found on my webpage cztherapy.com

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___ I understand that Chloe Zingaro, LCSW does not take any cases that involve legal disputes where it is the intention of the client to receive documentation to provide to a court or attorney.

___ If Chloe Zingaro, LCSW deems it necessary that my child/adolescent participate in DBT therapy then I as the parent understand that my participation in the parent DBT skills group is mandatory. Chloe will not work with parents who do not take an active role in their child's treatment and the family will be given referrals.

___ I understand that if I need to communicate with Chloe Zingaro, LCSW regarding my treatment or my child/adolescent's treatment I will schedule a session in the office. Chloe Zingaro, LCSW is happy to read emails with updates concerning the child/adolescent and time taken to reply to emails will be charged in 15-minute increments.

___ I understand that if my adolescent is driving to and from session AND misses an appointment, Chloe Zingaro, LCSW will NOT notify parent of the missed session and parent will be charged according to the cancellation policy.

___ I understand that Chloe Zingaro, LCSW does NOT send out appointment reminders but will be happy to confirm your appointment time by text if you have forgotten.

Client Signature/Parent Signature if minor

_____

Date
