Cybil Streett
SPORTS PSYCHOLOGY

NOTIFICATION OF INFORMED CONSENT (MINOR)

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

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

Limits to Confidentiality: I understand that my minor's case information is confidential and clinical notes and other relevant case information will not be released to any other party without my and my minor's written consent (verbal consent in an emergency). However, I also understand that therapists such as Cybil Streett are mandated reporters of suspected child, elder, and dependent adult abuse by law and, therefore, must report to the proper authorities should they become aware of any previously unreported abuse of the aforementioned. Additionally, I also understand that should my minor pose a potential danger to another or a danger to him/herself that the law requires that this information be reported to the proper authorities.

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

Patient's Rights: I understand that I have the right to discontinue my minor's treatment at any point if I am dissatisfied with the services. I can be provided with referrals to other resources to assist in my minor's adjustment if needed. I also understand that the purpose of psychotherapy is to provide help and if I believe my minor has received unethical treatment, I can report the matter to the Board of Behavioral Sciences.

Appointment Cancellation Policy: I understand that if I or my minor must cancel or change a scheduled appointment that I or my minor must do so 24-hours in advance. Appointments cancelled or changed less than 24-hours in advance will be charged at the full fee.

Cybil Streett, M.A. - Licensed Marriage and Family Therapist LMFT124858
205 Avenida Del Mar #1355, San Clemente, CA, 92674
949.441.0832

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Fees/Collections: I understand that a fee arrangement will be made with me at the commencement of treatment and that payment is due prior to or at the time of each session. I also understand that checks returned for nonpayment will result in an additional $25 charge for administration costs. Any changes in the fee arrangement must be made directly with Cybil Streett. I also understand that if I fail to pay for services promptly collection action may be taken. I will be responsible for any attorney fees and other collection costs.

Emergency: In case of an urgent need, Cybil Streett can be reached through the voicemail system at 949.441.0832. Calls are generally able to be answered within 24 hours. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety, the safety of your minor, or the safety of others, please call 911 to request emergency assistance. Please be aware of the following resources that are available in the community to assist individuals in crisis:

Crisis Hotline: (877) 7-CRISIS or (877) 727-4747

OC Warmline: (877) 910-WARM or (877) 910-9276

Domestic Violence Help: (800) 799-7233

Mission Hospital Psychiatric: 949-499-7501

Informed Consent: My signature below verifies that I have read and fully understand this Consent for Treatment Form.

Signature _____

Minor's Signature _____

Print Minor's Name _____

Date _____

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