From the office of Teri V. Krull, LCSW, LLC

TREATMENT RELEASE OF A MINOR

I understand that my child ____ DOB: _____________

Is scheduled to receive psychotherapy/play therapy from Teri Krull, LCSW. The purpose of this treatment is to improve my child's emotion health or to support my child in his or her adjustment to specific life issues. Ms. Krull's professional approaches include talk therapy: play therapy; sand tray therapy; cognitive behavioral strategies; guided imagery; hypnosis; EMDR and social skill development. I understand that she may also provide general education about mental health conditions or coping strategies. She may also assign my child "homework" to do between sessions. Possible benefits of treatment include improved mood; reduced stress; personal skill development and/or the resolution of problematic issues. I understand that a "cure" is not guaranteed and that it is possible that as my child works through issues in therapy, he or she may even feel or act worse. He or she may experience intense emotions as upsetting things are discussed and/or I may notice more conflict in relationships as my child make changes in behavior.

I understand that my child's therapy is confidential however this confidentiality is not absolute. In the case of medical emergency, child/elder abuse or neglect, suicidal or homicidal intent, or under court order, my child's clinical information may be released. While in most instances Ms. Krull does not contract with insurance companies, I do understand that if an insurance company pays for treatment, Ms. Krull will release clinical information to my insurer. In such cases, only that information required for billing or case management will be shared. I also understand that my child and Ms. Krull, with my approval, may limit information shared with me. I accept this condition of therapy and understand the importance of my child's privacy.

I understand that Ms. Krull as an independently licensed clinical social worker is not obligated to receive clinical supervision. However, in an effort to provide services that reflect best practices, she attends a monthly peer consultation group and she periodically consults with mental health and/or legal experts. I understand that if Ms. Krull discusses my case with a consultation group or with an expert consultant, she makes every effort to keep identifying information confidential. There are occasions when colleagues of Ms. Krull may provide emergency coverage. When this occurs, she may disclose certain information as necessary to ensure appropriate coverage.

I understand that I can receive a copy of my child's records (unless there is a circumstance that prohibits such release) or have a copy of those records provided to a third party if both parents and/or legal caretakers complete a Release of Information Form for that third party. I understand that there is a usual and customary charge for chart retrieval, chart review, copying of records, and a one-on-one meeting with Ms. Krull. A meeting is typically required prior to personal or parental receipt of a record. I acknowledge that Ms. Krull has discussed her policy regarding release of records when there is the possibility of litigation.

I understand that during the outbreak and variants of COVID-19, Ms. Krull may conduct treatment via telehealth. She most likely will use Zoom, FaceTime or Sessions for client contact. As the Caregiver I ask that she use : ZOOM_____; FaceTime ____; Sessions (HIPAA Compliant) _____ or the telephone ______ Initial your choice please. I agree with this form of contact for my child which may not be HIPAA compliant.

I understand that I have the right to participate in the treatment decisions made on behalf of my child. Ms. Krull, my child (when appropriate), and I will develop, periodically review, and revise a treatment plan that includes goals, interventions and time frames for completion. I understand that I have the right to refuse the recommended treatment and that I may withdraw this consent to treat at any time without consequence.

I understand that Ms. Krull bills at the following rates:

Service	Rate
Initial Diagnostic Interview (70 - 80 minutes)	$255 / (80-110 minutes) $300
Individual Psychotherapy (20-30 minutes)	$ 80
Individual Psychotherapy (38-45 minutes)	**$155**
Individual Psychotherapy (60 minutes)	$195
Hypnosis (40 to 60 minutes)	$155
Individual Psychotherapy (70-80 minutes)	$225
Group Psychotherapy	$ 80
Family Psychotherapy (60 minutes)	$195
Phone consults (15 minutes)	$ 55
No Show or Late Cancellation Fees (24-hour notice required)	$155
Record Review with client or agent (38-45 minutes)	$155
Charge Card Fee per transaction	3%

Ms. Krull does not contract with insurance companies, but clients may opt to file for out of network benefits. I understand that **I will be billed for cancelled sessions unless I give Ms. Krull 24-hour notice.** Since most insurance companies do not pay for a missed session, I understand that I am responsible for the full amount due. Ms. Krull may use a collection agency if fees on my child's account are not paid within a reasonable time frame.

Good Faith Estimates of Care may be offered or are available upon request.

PARENTS/CAREGIVER SIGNATURE: ________________________________ DATE: _______
Parents/Caregiver Signature: ____________________________________ DATE:________
WITNESS SIGNATURE: ____ DATE: _______