THE GOLD STANDARD
Casey Cooper, M.S., Ph.D. - Licensed Psychologist PSY21348
27201 Puerta Real, Suite 300
Mission Viejo, CA 92692
Telephone 949.306.3603

CLIENT INFORMATION (MINOR)

Today's Date: _____

Minor's Name: _____ Minor's Age: _____

Parents' Names: _____

Biological Parents are (Circle one): Married Separated Divorced Other_____

Minor's Home Address: _____

_____

Minor's Home Phone: _____Minor's Cell Phone: _____

Family Emails: _____

Parent's Address: (If different from minor) _____

_____

Parent's Home Phone: (If different from minor)_____

Parent's Business Phone: (Specify which parent) _____

Parent's Cell Phone: (Specify which parent) _____

Reason for Referral: _____

_____

Referral Source: _____

Any Current or Prior Medications: (Specify what medication is for and duration of prescription.)

_____

May we mail The Gold Standard information to your home address? Yes No

May we send Text Messages to the Cell Phone's Listed? Yes No

THE GOLD STANDARD
Casey Cooper, M.S., Ph.D. - Licensed Psychologist PSY21348
27201 Puerta Real, Suite 300
Mission Viejo, CA 92692
Telephone 949.306.3603

NOTIFICATION OF INFORMED CONSENT

Consent for Treatment: I, (print name)_____, authorize and request that The Gold Standard provide psychological examinations, 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. I understand that use of Telehealth increases my responsibility regarding privacy and will utilize the encrypted system offered by The Gold Standard in a private location with headphones.

Limits to Confidentiality: I understand that my case information is confidential and clinical notes, psychological testing results, and other relevant case information will not be released to any other party without my written consent (verbal consent in an emergency). However, I also understand that therapists at The Gold Standard 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 I pose a potential danger to another (C.C. 43.92 Violence Reporting Act) or a danger to myself (E.C. 1024) that the law requires that this information be reported to the proper authorities.

Telehealth:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the [Informed Consent Form or Statement of Disclosures] I received from my therapist also apply to my Telehealth services.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and my therapist may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.
6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.
7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.
9. I have discussed the fees charged for Telehealth with my therapist and agree to them.
10. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

Risk of Treatment: I understand that there is an expectation that I 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 I 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 treatment at any point if I am dissatisfied with the services. I can be provided with referrals to other resources to assist in my personal adjustment if needed. I also understand that the purpose of psychotherapy is to provide help and if I believe I have received unethical treatment at The Gold Standard, I can report the matter to the California Department of Consumer Affairs.

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

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 either Dr. Casey Cooper. 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 emergency, Dr. Casey Cooper can be reached through the voicemail system at The Gold Standard – (949) 306.3603.

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

_____ _____
Parent's Signature Date

_____ _____
Minor's Signature Date

_____
Print Minor's Name

Verbal Consent Obtained
Therapist reviewed Consent Form with Patient, Patient understands and agrees to the above advisements, and Patient has verbally consented to receiving psychotherapy services from Therapist via Telehealth.

_____ _____
Therapist's Signature Date