ERIC L. STRANG, PSY.D.

CLINICAL PSYCHOLOGIST

PHONE: (310) 450-2301 LICENSE # PSY 17729

Consent For Treatment of Child

This document is intended to provide you with important information about my professional services and business practices. Please read it carefully and make note of any questions you may have so we can discuss them at our next meeting.

Psychotherapy is not easily described in general terms since the form it will take varies with each individual client and therapist. In order to determine what psychotherapeutic treatment best suits your child's needs I will conduct an evaluation of them, their family situation, and the problems for which you are seeking treatment for them. This will occur during the first 2 to 4 sessions. Following this evaluation period, I will present you with my initial impressions and an outline of what treatment with me will entail. The evaluation period is also intended to give you and your child the opportunity to assess your comfort and confidence in working with me. Given the large commitment of time, money, and energy psychotherapy involves, you must be thoughtful about the therapist you chose. Any questions you might have about the verbal or written information I provide to you, or any matter that occurs between us, should be discussed with me as soon as possible. Should you choose not to pursue therapy with me I will be pleased to help you arrange an appropriate consultation with another therapist.

Psychotherapy has both benefits and risks. Some of the risks include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. While these feelings are a normal part of the therapeutic process, they can be quite intense and overwhelming at times. Though psychotherapy often requires recalling unpleasant events, familial background and relationships, it has been shown to have benefits for those who undertake it. Psychotherapy often leads to a significant reduction in one's feelings of distress, an improvement in one's relationships and the resolution of specific problems. There are, however, no guarantees about the outcome.

Sessions

Sessions will be scheduled to last 45-50 minutes. Your appointment time is reserved for you / your child. Once you have scheduled a session, you will be expected to pay for it unless you provide at least 48 hours advanced notice. In situations where your absence was beyond your control, and where time permits, I will attempt to reschedule your session.

Fees & Payment

It is my practice to charge a prorated fee for other professional services you request such as report writing, telephone conversations lasting longer than 10 minutes, consultations with other professionals, preparation of treatment summaries etc. If you require me to participate in a legal proceeding, I will charge $300 per hour due to the complexity and difficulty of such activity. Unless otherwise arranged, you will be expected to pay following each session. In order to maximize the time spent on your treatment it is suggested that you have your check completed in advance.

Between Session Contact

Please be aware that I am not available immediately by phone. I am however, alerted when a message has been left on my voicemail service. I am usually able to return calls within an hour. Whenever I am out of town I will leave you with information for contacting a trusted colleague who will be available to deal with any emergency you may have.

Client Rights

1. You have the right to decide not to have your child enter therapy with me. If you wish, I will provide you with the names of other therapists and clinics.
2. You have the right to end therapy at any time. The only thing you will have to do is pay for any treatments you have already had.
3. You have the right to ask any questions about what we do during therapy and receive answers that satisfy you.
4. You have the right not to allow the use of any therapeutic technique.

The signatures here show that we each have read, discussed, understood, and agreed to abide by the points presented above.

_____ _____

Signature of Parent Date

_____

Printed name

_____ _____

Signature of therapist Date