Joint legal custody issues:

I am glad that I will have an opportunity to work with your child/children. In order to get started, the paperwork that follows needs to be completed by both parents who have joint legal custody of the children who are coming for counseling. When divorced parents share legal custody, they are usually entitled to be involved in the mental health care of their child. This does not mean that both parents will be involved in the counseling process – it just means that both parents consent and know that they are entitled to know about their child's mental health progress if they so choose. Please read this letter and all the paperwork that follows carefully and contact me directly (760-494-4394-text messages are not received at this number) if you have any questions.

Joint legal custody is defined by the courts – typically, it applies to the two biological parents of a child (or children) who have divorced, and gives each parent the ability to make decisions on behalf of their child/children. The court decides who has legal custody and notes this on the divorce documentation. Legal custody is not the same as visitation, physical custody, or where the child resides.

When a divorce has occurred, contact between former spouses can result in tension. To limit this I take the following position and set the following boundaries:

1. When a couple divorces, they essentially create two separate families – the child belongs to both families, but each spouse is typically excluded from the other – this is the basic premise of a divorce.
2. Because I am a family therapist, I am open to hearing from both parents, though I do not require it. I am interested in both parent's perspective on their child's mental health and behavior. The exceptions are extreme cases where I deem such communication unhelpful to the therapeutic process (e.g., the other parent is incarcerated, or is incapacitated due to chronic drug addiction).
3. I work directly with the family that initiates the counseling process, because they are the family who has hired me to help the situation. I work indirectly with the other parent, if they want to be involved.
4. If both parents are "friendly with each other" it is occasionally possible and sometimes helpful to have meetings that may involve both parents – this is rare, but in some cases, when all parties agree, it can be helpful. It is not required, however, and is dependant solely on the situation presented.
5. If both parents are "not friendly with each other" and I deem that they are incapable of working together, or that the direct involvement of both parents in counseling is detrimental, I will limit my work to the family that hired me; but I may remain open to communication with the other parent.
6. There are extreme situations in which I would not be open to communications from the other parent who may have legal custody (child abuse, incest, violence, other forms of abuse or danger). This is a matter of state law which gives mental health professionals discretion as to limit-setting within family therapy. If you have any questions, feel free to contact me directly (760-494-4394).

I have joint legal custody of _____

Child or children's name(s)

I understand what is written above _____

Parent with joint legal custody

Jussi Light*, M.A. Licensed Marriage & Family Therapist MFC #39617*

Informed Consent for Families with Minors (ages 17 and younger)

Your signature at the bottom of this page means that you understand and consent to the following policies and procedures:

Counseling is a collaborative process between therapist and patient(s) who work together on mutually agreed upon goals. Participation is voluntary and is only effective when both patient(s) and therapist are actively striving for the patient's growth and change. Patients realize that participation in therapy can involve discussing issues that may be distressing – however, therapy is designed to help patients personally and in their relationships. When minors are involved, it may be necessary that parent(s)/guardian(s) participate in the counseling process with their child(ren) at the discretion of the therapist. Some problems may be best resolved with the participation of other family members or close relations.

Appointments are made in advance and start and end on time – a session lasts 50 minutes. If a patient is late, the session will still cost full price and end at the pre-arranged time. 24-hour advance notice is expected for cancellation or rescheduling. Any patient who fails to cancel, cancels at the "last minute," or doesn't attend a regularly scheduled session *will be held responsible for full payment of the missed session.* Lateness, or cancellations made by the therapist will be rescheduled.

Emergencies: in the event of an emergency dial 911 or 800-479-3339. The therapist is available via telephone (760-494-4394 – sorry text messages are not received at this number) during business hours and will return emergency calls at his discretion. However, most phone calls will be returned during normal business hours on weekdays.

Payment is expected at the time of service and will be collected at the beginning of the session. Any check that is returned for insufficient funds will be assessed a $25 fee.

Confidentiality is vital to trust - all sessions are confidential. This means the therapist will not discuss any aspect of the session or case with anyone outside of therapy without prior written consent of patient(s). It is important that all patients (especially children) have a confidential relationship with their therapist.

- Individuals attending therapy due to a **court mandate** or as consequence or condition of probation/parole may have to waive their rights to confidentiality and the therapist may be able to communicate to your probation/parole officer regarding your case.
- If you have **health insurance** that covers services, a minimum of information will need to be exchanged to insure reimbursement – however, you will be required to sign an authorization to release information.
- **Secrets** within relationships sometimes can be destructive or counter-productive to the goals of therapy. If a patient divulges such a secret to the therapist, the therapist will use his discretion about revealing it. Generally, the therapist will ask the patient to divulge the secret – if the therapist believes the secret is destructive or counter-productive to the counseling process, he may refuse to continue working with the patient until the patient reveals the secret. In cases of danger, the therapist may reveal the secret to maintain safety.

Limits of confidentiality: The following are exceptions to confidentiality and *MUST BE REPORTED* to the appropriate service and/or police. Please note – these reports are mandated by law and may be made without your consent or written permission.

1. If a client(s) become a danger to himself/herself, steps will be taken to keep the client safe.
2. If the client should become a danger to another identifiable person(s), the potential victim(s) will be warned and the police will be notified.
3. Any suspicion of child abuse (including physical, sexual, and/or emotional abuse as well as child neglect or endangerment) whether past or present, previously reported or not, will be reported.
4. Any abuse or neglect of an elder or dependent adult will be reported to Adult Protective Services.

I authorize Jussi light to leave voice messages at my home or with a family member or friend regarding appointments, billing issues, or other pertinent information regarding my Behavioral Health Care. **YES / NO** (choose one) _____

Only parent(s) or legal guardian(s) can give authorization for the treatment of minors. If both parents have legal custody, both parents' signatures are required for treatment. If someone other than the parent(s)holds guardianship, legal documentation must be presented prior to authorizing treatment. If there are legal stipulations (a court order) that both parents must consent to ongoing treatment, I agree to contact the other parent and forward his/her consent for treatment to my child's therapist prior to treatment.

I hereby consent to the treatment of my child(ren):_____

Print child(ren) name(s)

I agreed to the above policies:_____

Parent/Legal Guardian Signature(s) Date

***Jussi Light**, **M.A.** Licensed Marriage & Family Therapist MFC #39617*

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand that Jussi Light uses administrative staff to perform basic clerical functions that are ordinary and typical to run his therapy practice. Jussi Light's staff will ONLY have access to the following types of information about those attending therapy:

1. Demographic information (names, addresses, telephone numbers, email addresses, dates of birth, etc.) taken from client intake questionnaire.
2. Billing information (names, dates, charges, payments, payment methods, diagnostic codes, etc.).
3. Emergency contacts – in the unlikely event that Jussi Light becomes so ill or incapacitated that he is unable to contact me/us, staff may contact me/us regarding logistical issues (for example, to cancel an appointment for Jussi when he is sick).

Staff will not have access to information about the content of counseling and therapy sessions. Staff will not have access to information about any communications (such as telephone, email, mail) that pertain to counseling and therapy matters.

If I am involved in paying therapy fees to Jussi Light directly, I further understand that administrative staff will send me a monthly statement which acts as a receipt for payments received. It includes billing information (such as a diagnosis, billing codes, patient name, etc.) and is typically sent to me via email. Please check only one:

☐ I probably will not be paying Jussi Light directly for any fees associated with therapy.

☐ I will accept monthly statements by email. Please send them to the following email address:

please print clearly: _____

☐ I do not want my monthly statement sent via email. Please give them to me directly at sessions.

By singing below, I understand and agree to the contents of this form.

Name: _____ date: _____

Email communications with Jussi Light

Please read the following disclosures about communicating with Jussi Light using email:

1. Email is a non-secure and non-confidential form of communication. Hackers and unauthorized users can also attempt to access emails through malicious software such as spyware or a virus that may be located on your computer unbeknownst to you.
2. Many people still feel comfortable communicating via email because they have installed firewalls or other programs designed to detect spyware, viruses, or other dangerous software. However, there is no guarantee that such programs will work 100%.
3. Sent and received emails are stored on both Jussi Light's and your computer until deleted. Jussi Light may or may not delete such emails. Generally, mundane emails (questions about appointments, billing, etc) will be deleted while other emails may be kept for archival purposes. Any such saved emails will be kept in a password-protected account that only Jussi Light has access to.
4. In addition, whenever you send an email, it is stored in cyberspace and the authorities can access these emails under various circumstances – this is not a policy of Jussi Light, but is due to the nature in which email is transmitted using the internet and other services or networks. For more information on this, please contact your Internet Service Provider or email service.
5. Jussi Light will use email to respond to emails that you send him. If you request that your billing statement be emailed to you, he will do so.
6. As a rule, Jussi Light does not conduct therapy via email. However, he may use email to handle certain questions/issues that pertain to therapy and related content if they can be easily and simply handled over email. He may also choose not to use email to handle such matters. He will tell you if this is the case.

By singing below, I agree that I understand the disclosures listed above regarding communicating with Jussi Light using email. I also agree that if I send an email to him and request a response via email, that I am willing to accept the above-stated risks:

If you do not want to correspond via email do not sign your name – instead, write "declined."

Print Name:_____Signature_____Date:_____

Permission for Jussi light to initiate emails to you

Sign below if you give your permission for Jussi Light to initiate sending emails to you. Example: Jussi may be the first one to send an email to you, rather than just responding to your emails.

If you do not wish to have Jussi Light initiate emails to you, do not sign your name – instead, write "declined."

Print Name:_____Signature_____Date:_____

Print your email clearly:_____