MINOR PATIENT INFORMATION

Name: _____

Address: _____

_____

Cell Phone: _____

Date of Birth: _____

Social Security Number: _____

Parent/Guardian Name: _____

Address (if different): _____

Home or Cell Phone: _____

Who referred you to Dr. Anderson? _____

May we contact them to thank them for the referral? Yes No

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Shannae Anderson, Ph.D. Date

PATIENT CONTRACT AND CONSENT FOR TREATMENT OF MINORS

PATIENT'S RIGHTS:

All Patients within this practice will be treated in a manner that upholds their personal dignity and that treats them equally, without regard to sex, age, race, religion, or handicap. Patients have a right to refuse treatment at any time. However, any non-compliance with specific treatment recommendations must be discussed thoroughly with Dr. Anderson. In addition, a written statement of chosen non-compliance with treatment recommendations may be requested. Patients have the right and are encouraged to discuss treatment planning and on-going progress with Dr. Anderson.

PAYMENT:

Individual psychotherapy sessions are 50 minutes in duration, and payment is required in full at the time services are rendered. Dr. Anderson's fee is $250.00 per therapy hour. Payment can be made by cash, check, Venmo, or credit card (Visa or MasterCard). Dr. Anderson is not on any insurance panels but can provide a superbill on a monthly basis for insurance reimbursement. There will be a $25 service charge on any payment returned for insufficient funds. Dr. Anderson reserves the right to charge a 10% interest fee on any unpaid balance beyond 30 days.

CANCELLATION POLICY:

Because time has specifically been reserved for you, a 24-hour notice is required for all cancellations. A failure to give a 24-hour cancellation notice will result in a full charge for this time.

CONFIDENTIALITY:

All information disclosed and discussed within the therapeutic setting is confidential. No information will be shared with individuals outside of this treatment practice. To ensure that the highest quality of care is delivered, case discussion, consultation, and supervision may be sought within this treatment practice. If it is desired to share information with involved individuals outside this treatment practice, a specific consent form will be requested in writing. Information not bound under the state guidelines for Patient confidentiality includes

a) Information regarding the abuse and/or neglect of a child or elder adult;
b) Information regarding the intent to harm self and/or others;
c) Court subpoena of records and/or Dr. Anderson.

CONSENT FOR EVALUATION AND TREATMENT:

I hereby certify that I have read and understood the above treatment terms and contract. Consent is therefore given for my evaluation and treatment by Shannae Anderson, Ph.D.

_____	_____
Patient Signature	Date
_____	_____
Parent/Guardian Signature	Date
_____	_____
Shannae Anderson, Ph.D.	Date

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face
We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting/returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. ___
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee. _
- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time. ___
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. ___
- You will adhere to the safe distancing precautions we have set up in the waiting room and therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.___
- You will wear a mask in all areas of the office (I will too), unless mutually agreed not to. ___
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me. ___
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. ___
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. ___
- You will take steps between appointments to minimize your exposure to COVID. ___

- If you have a job that exposes you to other people who are infected, you will immediately let me know. __
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me know. __
- If a resident of your home tests positive for the infection, you will immediately let me know and we will then resume treatment via telehealth.__

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, and all of our families safe from the spread of this virus. If you show up for an appointment and I believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____
Patient Date

_____ _____
Shannae Anderson, Ph.D. Date