John Dunn, MA, LCPAT, ATR-BC
Annapolis Art Therapy
1831 Forest Drive Suite F
Annapolis, MD 21401
443-603-5484 (Cell)

Consent to Treat for Minor Clients

Welcome. You are contemplating taking an important step in caring for your child and family: to explore a challenge that life has presented to you, through the process of art therapy. There is no requirement for possessing artistic skill or training. Humans have used art to express themselves since the earliest times; think of those pre-historic cave paintings. Your child or teen can be expressive through art even if they don't see themselves as especially artistic.

I appreciate the opportunity to serve you. I am a licensed and board certified art therapist with a Masters in Art Therapy. My clinical experience includes working in inpatient and residential psychiatric settings with children, adolescents, adults and the elderly with a wide range of clinical diagnoses. I have worked with individuals and groups, in brief therapy and in long-term interventions. My theoretical approach is eclectic, informed by psychodynamic, creativity theory, positive psychology, trauma and attachment theory. I utilize creative, verbal, and experiential modalities, depending on client needs. I may assign out-of-session work.

While it may not be easy to seek help from a mental health professional, I hope that by doing so, the minor child in your care will be better able to understand their situation and feelings, and to move toward resolving challenges. It will be important for you to support your child in trying out new approaches in order for change to occur. I will use my knowledge of human behavior and development and my understanding of the creative process to guide your child toward discovering resources they may already possess or that they may choose to develop for good health and well-being. You may bring other family members to a therapy session if you and I agree that it would be helpful. I may request that you join us in session or for part of a session. It is my experience that a healthy attachment between a child and parent/adult caregiver is essential for productive and positive psychological growth and development.

CLIENT INFORMATION AND CONSENT

The following policies are to help ensure that our work together proceeds smoothly with the high level of mutual respect that is essential for success. Please ask any questions that you may have about the following:

APPOINTMENTS, CANCELLATIONS, AND MISSED APPOINTMENTS

All services are provided by appointment. Treatment needs vary so I will work with you to set up the most appropriate schedule. I generally schedule individual sessions of 50 minutes. Intervals between appointments vary depending on your needs. Call **443-603-5484** to schedule an appointment. The time that you reserve for your appointment is valuable. If you are unable to come at the time you have reserved, please give me as much notice as possible. *Appointments canceled with less than 24 hours notice, or missed without notice, will be billed at the regular rate.*

PAYMENT FOR SERVICES, HEALTH INSURANCE / MANAGED CARE

The fee for individual psychotherapy is $100.00 per session. If you are unable to meet the expense ofbc/ treatment under the standard fee schedule, please discuss your circumstances with me. I participate in Carefirst BC/BS PPO and EPO networks but not BC/BS HMO networks. Other insurance plans are billed out of network. If you will be submitting insurance claims please let me know in advance and I will provide you with an invoice for services. **Payment, by personal check, cash or credit card is due at time of service unless previously arranged.**

CONTACT OUTSIDE OF APPOINTMENTS

Questions and concerns arise that can be addressed in a brief telephone conversation or email. Please feel free to leave me a confidential message at **443-603-5484** or email me at **jfpdunn@annapolisarttherapy.com**. I will respond as soon as possible or within 24 hours. I consider occasional phone calls or emails to be part ordinary treatment and I do not bill separately for them. There may be a charge for extended telephone time or email responses.

EMERGENCY CARE, URGENT CARE, AND THERAPIST ABSENCE

In case of a mental health care emergency requiring immediate action please call your psychiatrist or go to your local emergency room, then contact me at **443-603-5484 .** I will return your call as soon as possible. If I am unavailable and you need urgent care, within 48 hours, please call your psychiatrist or contact OASIS: The Center for Mental Health at **(410) 571-0888.** If I have travel plans that coincide with your scheduled care, I will inform you in advance and work with you to plan for my absence. If I have an emergency I will contact you and reschedule our session.

CONFIDENTIALITY:

Discussions between a therapist and client are confidential. No information will be released without your written

consent unless mandated by law. Possible exceptions to this include but are not limited to the following situations; child abuse, abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; child custody cases; suits in which the mental health of a party is in issue; situations where a therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; a negligence suit brought by the client against the therapist; or the filing of a complaint with a licensing board. Any psychotherapy notes taken will not be available for your inspection. In addition, I do not provide job, school or other references. I do not participate in social networking with clients. If you have any questions about confidentiality please bring them to my attention and we can discuss them. By signing this information and consent form you are giving me your consent to share confidential information, including process note with all persons mandated by law and with your insurance company, if you require receipts for services rendered, and you are also releasing me from any departure from your right of confidentiality that may result.

DUTY TO WARN

In the event that John Dunn, MA, LCPAT, ATR-BC reasonably believes that I am, or my child is, in danger, physically or emotionally, to myself/him/her self or another person, I consent for her to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

Name	Telephone Number

I consent for John Dunn, MA, LCPAT, ATR-BC to communicate with me by mail or by phone at the following addresses and phone numbers. I will immediately advise him in the event of a change.
Current Contact Information:

My Home Address:
My Telephone Number(s):
My Email Address:

RISKS OF THERAPY

Often, growth cannot occur without confronting issues that induce feelings of sadness, anxiety, or pain. The success of therapy depends on the quality of effort on both the part of the therapist and client/family. It also depends on the client's willingness to take responsibility for lifestyle choices/changes that may result from therapy. Specifically, risks of therapy include the possibility of disrupting significant relationships.

IN CASE OF THERAPIST INCAPACITY OR DEATH

By signing this information and consent form, I give my consent to allowing another licensed mental health professional selected by John Dunn to take possession of my file and records and provide me with copies on request.

CONSENT TO TREATMENT

I, ________________________________voluntarily, agree that the child in my guardianship, _______________ ____________________________________, receive mental health assessment, care, treatment and services, and authorize John Dunn, MA, LCPAT, ATR-BC to provide such care, treatment, or services as are considered necessary and advisable within the scope and standards of her professional training and practice.
I understand and agree that I will participate in the planning of my child's care, treatment or services, and that I may stop such care, treatment, or services that my child receives from John Dunn, MA, LPCAT, ATR-BC at any time.
By signing this Client Information and Consent form, I, the undersigned parent/adult caregiver acknowledge that I have both read and understood all the terms and information contained in this consent. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

____ ________________________
Client/Parent/Guardian Date

____________________________________ __________________________
Date

John Dunn, MA, LCPAT, ATR-BC
NPI#: 1447691746; Art Therapy Credentials Board Cert.#00-138; State of Maryland License # ATC017