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DISCLOSURE OF MINOR'S TREATMENT INFORMATION TO PARENTS: Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children and adolescents to have a "zone of privacy" where they can feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child or adolescent's treatment, but NOT to share specific information that he or she has disclosed to me without your child/adolescent's agreement. This includes activities and behavior that you might not approve of, but do not put your child at risk of serious and immediate harm. However, if your child/adolescent's risk-taking behaviors becomes more serious, then I will need to use my professional judgment to decide whether he or she is in serious and immediate danger of harm. If I feel that your child/adolescent is in such danger, I will communicate this information to you.

Even when we have agreed to keep your child's treatment information from you, I may believe that it is important for you to know about a particular situation that is going on in your child/adolescent's life. In these situations, I will encourage your child/adolescent to tell you, and I will help he or she to find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child/adolescent.

DISCLOSURE OF MINOR'S TREATMENT RECORDS TO PARENTS: Although the laws of California may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen will have a "zone of privacy" in their sessions with me, and you agree not to request access to your child or adolescent's written treatment records.

PARENT/GUARDIAN AGREEMENT NOT TO USE MINOR'S THERAPY INFORMATION/RECORDS IN CUSTODY LITIGATION: When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone,

particularly for the children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/ visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem,* or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $320.00 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress and/or may be asked to participate in therapy sessions as needed. _____ _____

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child or adolescent's treatment. _____ _____

I understand that I will be informed about situations that could endanger my child. I know the decision to breach confidentiality in these circumstances is up to Dr. Bonaventura's professional judgment, unless otherwise noted above. _____ _____

Parent/Guardian Signature_____ Date_____

Parent/Guardian Signature_____Date_____