Little Wildflower Play Therapy, LLC
(605) 627-1494
littlewildflowerplaytherapy.com
littlewildflowerplaytherapy@gmail.com

**Informed Consent**

Thank you for choosing Little Wildflower Play Therapy, LLC. This is intended to give you information relevant to your therapy, rights, exceptions of confidentiality, and office policies. Please read carefully through these pages and ask any questions you may have. Your signature(s) will indicate that you have read, understood, and accepted these conditions.

**Authorization for Minor's Mental Health Treatment**
In order to authorize mental health treatment for your child, **both** parents will be asked to consent and sign this agreement, prior to Brooke Rustman, LPC-MH, RPT™ will provide mental health treatment to your child. In the event of divorced parents, a copy of your current custody order must accompany your consent. We reserve the right to make very limited exceptions to the requirement that both parents consent to mental health treatment under the proper extenuating circumstances.

**Nature of Treatment**
Your child will receive mental health treatment, including, but not limited to individual therapy, play therapy, or other therapeutic techniques designed to address emotional or psychological concerns. Treatment modalities will be explained by the therapist and tailored to your child's needs. Additionally, parent supports will be provided throughout your child's treatment as well.

**Risks and Benefits**
The goal of treatment is to help you child improve their emotional well-being, manage stress, and address any mental health concerns. Success in therapy may take time, and benefits vary among individuals.
While therapy can be beneficial, it may also bring up difficult emotions or memories. Sometimes, children may initially feel worse before they feel better. The therapist's role is to help minimize these effects and support your child and your family through the process.

**Confidentiality**
Little Wildflower Play Therapy, LLC iis bound by the South Dakota Administrative Code for health and safety. In accordance with these rules, information obtained in the counseling session or in written form will not be disclosed to any outside person(s) or agency without your written permission except when such disclosure is necessary, such as:

a. “Protect you or someone else from imminent harm” or is otherwise legally required and/or allowed by law (such as abuse of a child, elder, or disabled person or court order). Therefore, if you make a serious threat to harm yourself or another person, the law requires me to try to protect you or that other person.
b. If you were sent to me by a court or an employer for evaluation or treatment, the court or employer expects a report from me. If this is your situation, please talk to me before you tell me anything you do not want the court or employer to know. You have a right to tell me only what you are comfortable with telling.
c. 3. If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize release to other parties.
d. Furthermore, if you want your insurance to pay for all or part of your treatment, I must be able to discuss your diagnosis and treatment with their representative. Some insurance information is transmitted to billing personal by secure fax or electronic transmission.

**Alternatives to Treatment**
You have the option not to pursue therapy for your child. There are also alternative treatment options, including other forms of therapy or treatment programs that may be more suited to your child’s needs.

**Voluntary Participation**
Your child’s participation in therapy is voluntary, and you or your child can withdraw consent at any time. If you choose to stop therapy, the therapist will help you understand how to transition out of treatment safely.

**Assent**
In addition to your consent, your child will be asked to provide assent, meaning that they agree to participate in treatment. Your child’s assent is important and we will work with them to ensure they understand the process.

**Insurance and Fees**
If you have a health insurance policy, it usually provides some coverage for mental health treatment. Our office will submit all claims on your behalf. However, you (not your insurance company) are responsible for full payment of the fee. Please contact your insurance company to learn about your mental health benefits and copayments and to determine if pre-authorization is required for mental health services. Co-pays will be charged after each session with the credit card on file. Any additional fees (i.e. excessive communication, report writing, or deductibles) are due immediately.

Any phone calls or extended text messaging, after the initial evaluation, relating to the client, lasting longer than 10 minutes, will be billed at a 10-minute increment (rounded to the nearest 10 min mark) at $20 per 10-minute increment.

As part of the therapeutic process, the therapist does not feel it is beneficial to the treatment process to participate in any legal process concerning therapy that was given through Little Wildflower Play Therapy, LLC. If requested, the therapist will decline. If it becomes necessary to participate (e.g. court order, subpoena), the hourly rate for this therapist’s preparation and

testimony in a court hearing is $275 per hour, and payment will be required in advance. This hourly rate includes any and all time listed on the subpoena, regardless of actual testimony time, as we are unable to schedule other clients during these times. This rate begins from the time I leave the office for the courthouse and ends when testimony is complete and we are dismissed from the courtroom. This fee also includes any communication with your lawyer prior to my testimony.

Little Wildflower Play Therapy, LLC is within network of various insurance providers, while also offering self pay fees as displayed below if you are not interested in submitting sessions to your insurance. (**as of 6/9/25)**

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| 45 minute session | $175 |
| 60 minute session | $200 |
| Initial Intake | $225 |
| Cancellation Fee | $75 |
| **We off $25 per session self pay discount for those enrolled in AutoPay with CC. | |
| Play Therapy/EMDR | $25 additional per session |

**Self Pay Client's Scheduled Parent Consults** will be billed at the following rates. This includes virtual and/or in person sessions. Auto Pay discounts are not applicable to parent consults.

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| 60 minute session | $175 |

**Cancellation Policy**
Consistent attendance at your sessions is critical to your therapeutic success. The session cancellation policy is as follows: Unless you provide 24-hours advanced notice of cancellation or the clinician is able to fill your scheduled hour, you will be charged a $75 fee. If your appointment is on a Monday or the day after a holiday, your appointment is required to be canceled 24-hours in advance on the previous business day. Insurance cannot be used for sessions that are missed. In the event that you do not provide 24-hours advance notice, you will be responsible for paying the fee rate.

**Recording**
There is to be no recording during the session by the client or anyone associated with the client. If someone records the session unknowingly to the therapist, There is a $2,000 fee per session.

**Emergencies**

If an emergency situation arises for which you feel immediate attention is necessary, including suicidal or homicidal thoughts and/or actions, feel free to contact the provider and if the provider does not make contact within 15 minutes, then contact emergency services (911) immediately or go to your nearest hospital emergency room.

**Social Networks**
Due to confidentiality, we will not accept contact requests with you on any social networks because doing so can compromise your confidentiality, as well as our respective privacy. It may also affect the boundaries of our therapeutic relationship.

**Agreement for Parents & Guardians**
In order to best help your child, Little Wildflower Play Therapy, LLC strongly recommends that each of the child's caregivers (e.g. parents, stepparents, guardian, etc.) mutually accept the following requisites for the child's participation in therapy:
1) As your child's counselor, it is my primary responsibility to respond to your child's emotional needs. This includes, but is not limited to, contact with your child and each of his or her caregivers and gathering information relevant to understanding the best welfare of your child.
2) We ask that all caregivers remain in frequent communication regarding this child's welfare and emotional well-being.
3) We ask that all parties recognize and reaffirm that to the child, that I am the child's helper and not allied with any disputing party.
4) We strongly recommend that all caregivers involved choose to participate in psychoeducation for the best interest of the child.

**Individual Parent/Guardian Communications with Treating Professional**
In the course of the counselor's treatment of your child, the counselor may meet with the child's parents or guardians either separately or together. Please be aware, however, that, at all times, your counselor's patient is your child – not the parents or guardians nor any siblings or other family members of the child.

**Disclosure of Minor's Treatment Records to Parents**
ALTHOUGH THE LAW MAY GIVE PARENTS THE RIGHT TO SEE WRITTEN RECORDS YOUR COUNSELOR KEEPS ABOUT YOUR CHILD'S TREATMENT, BY SIGNING THIS AGREEMENT, YOU ARE AGREEING THAT YOUR CHILD OR TEEN SHOULD HAVE A "ZONE OF PRIVACY" IN THEIR MEETINGS WITH THEIR COUNSELOR AND YOU AGREE NOT TO REQUEST ACCESS TO YOUR CHILD'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 children. Although your counselor's responsibility to your child may require that he or she is helping to address conflicts between the child's parents, the counselor's role will be strictly limited to providing treatment to your child. You agree that in any child custody or visitation proceedings, neither of you will seek to subpoena your counselors' records or ask your counselor to testify in court, whether in person or by affidavit, or

to provide letters or documentation expressing his or her opinion about parental fitness or custody or visitation arrangements. Please note that your agreement may not prevent a judge from requiring the counselor's testimony, even though the counselor will not do so unless legally compelled. If your counselor is required to testify, he or she is ethically bound not to give his or her opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, the counselor will provide information as needed, if appropriate releases are signed or a court order is provided. However, the counselor will not make any recommendation about the final decision(s). Furthermore, if the counselor is required to appear as a witness or to otherwise perform work related to any legal matter, regardless of who requires your counselor to attend, you agree to reimburse the counselor at an hourly rate of $275 per hour for the time spent traveling, speaking with attorneys, reviewing, and preparing documents, testifying, being in attendance, and any other case-related costs.

My signature indicates that I understand and agree to the above.

**Child/Adolescent Patient (if over the age of 16)**
By signing below, you agree that you have read and understood the policies described above. If you have any questions as you progress with therapy, you can ask the counselor at any time.
Minor's
signature*_____Date_____

**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's/adolescent's treatment.

_____ _____

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

_____ _____

Parent/Guardian
Signature_____Date_____

Parent/Guardian
Signature_____Date_____