JuanCamiloMantillaG
Psicólogo / Psychologist

CONFIDENTIALITY AGREEMENT

On behalf of _____, with ID _____, we, the parents, express our acceptance of psychological treatment offered by Dr. Mantilla, which has been explained and understood by us.

We have full knowledge and agree that the personal situation and treatment of our son/daughter will be discussed with other relevant professionals as Dr. Mantilla deems suitable, in order to offer an interdisciplinary treatment if necessary. For this reason, we authorize the doctor to refer our son/daughter to other professionals or third party experts, or to send him/her to see a specialist to provide the best possible treatment. The result of this consultation will be communicated to us verbally.

We understand that all information concerning the evaluation and treatment, including any recording of audio, video, Gesell dome sessions or written reports, are confidential and will not be disclosed or given to any institution or individual without our express consent, except when the order comes from a competent court. We also understand and therefore we agree with the need to break this principle of confidentiality in the case of situations that seriously endanger the physical or mental integrity of our son/daughter or that of a member of the community. The assessment of the seriousness of the situation that will violate the principle of confidentiality will be determined by Dr. Mantilla, who will give us a written or verbal notification about this situation and who does not need our express consent on this matter.

We understand that the treatment provided is carried out based on suitable and effective alternative psychological models and on the empirical and analytical model, which has wide acceptance in the scientific community, according to the criteria that the doctor has regarding the best treatment to apply in this case. We are also aware that in some cases, these models could work better than others. The decision will be based on a thorough evaluation and after analyzing the choices, beliefs and symptomatic variables as well as the social, cultural, behavioral, emotional and cognitive skills of our son/daughter. Additionally, we acknowledge that the information provided is true and corresponds to the reality of our son/daughter, since on such information is posed the proposals for action.

We comprehend that the duration of this treatment depends on the severity of the case and that the number of sessions per week may vary according to the discretion of the doctor and the agreements we reach concerning them. First sessions will focus on the assessment of the case and we will be informed how we can be helped. If for some reason the doctor cannot provide us with or offer the kind of service we require, we will be referred to the appropriate institution or professionals.

We also know that decisions about the continuation or suspension of the activities planned for the evaluation and treatment of the issues at stake, are taken by us and our son/daughter. The therapeutic process requires our commitment on issues such as attendance, punctuality and participation and collaboration filling in a number of documents and psychometric testing with personal information which will be used for evaluation and treatment.

In case, our son/daughter cannot come to a session it is our duty to call off 3 hours before, in order to avoid the full payment of the session and be able to book another one.

We expressly declare that we have read and understood this entire document and its content and therefore accept the consequences resulting therefrom.

I have read, understood and agreed to the above.

Full Name (Father):_____

Signature: _____ Date: ____/____/_____

ID: _____

Full Name (Mother):_____

Signature: _____ Date: ____/____/_____

ID: _____