C.G. JUNG INSTITUTE OF LOS ANGELES

HILDE KIRSCH CHILDREN'S CENTER

10349 West Pico Blvd. Los Angeles, CA 90064
Phone: 310.556.1193 • Fax: 310.556.2290 • office@junginla.org • www.junginla.org

APPLICATION FOR TREATMENT

Child's Name		
Child's Address	City	Zip
Child's Telephone	Date of Birth	Age

Mother's Name		
Mother's Address	City	Zip
Home Telephone	Work Telephone	
Occupation / Employer	Gross monthly income before taxes [Please attach your latest schedule 1040 or your last three paycheck stubs]	
Cell Phone	E-mail	

Father's Name		
Father's Address	City	Zip
Home Telephone	Work Telephone	
Occupation / Employer	Gross monthly income before taxes [Please attach your latest schedule 1040 or your last three paycheck stubs]	
Cell Phone	E-mail	

Siblings Names and Ages		
Child's School		
Grade	Teacher	
Pediatrician	Medical Insurance	
	❑ YES	❑ NO

State why you are applying to the Children's Center at this time. Please include any information which may be helpful in evaluating your application. All information will be kept confidential. (Use reverse side for additional space.) Sign enclosed release form.

Referral Source: _____

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AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

I hereby apply for psychological treatment of my child, _____, at the Hilde Kirsch Children's Center of the C. G. Jung Institute of Los Angeles. I authorize the Children's Center Director to release information as necessary when assigning me to a clinic therapist. I understand that the Children's Center, as part of the C. G. Jung Institute, is involved in training, and that my assigned therapist may be an analyst, or in the analyst training program or internship program. Children's Center clinicians come from a variety of mental health disciplines which includes psychology, social work, psychiatry, and psychiatric nursing. I understand that my child's therapist may review the process of the therapy in staff colloquia or meetings and with his/her supervisor and/or the clinic director.

Clinic policy is to charge for any session not cancelled at least 48 hours before the scheduled appointment. I understand this policy and will be responsible for payment of any session not cancelled with 48 hours notice.

Confidentiality between patient and therapist is very important in a therapeutic relationship. Even in the context of supervision, as mentioned above, names and privacy shall be carefully protected. However, there are specific circumstances mandated by California law where confidentiality between patient and therapist may or must be broken. These situations involve child abuse, elder abuse, spousal abuse, threat or harm to oneself or to another person. Your therapist is well-informed of the mandated reporting laws. Please feel free to discuss any concerns you may have about situations where there may be limits to confidentiality.

I agree to participate in the treatment process as required by the clinicians invloved.

_____ _____

Parent (Mother or Guardian) Parent (Father or Guardian)