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Informed Consent

(5 Pages. Revised 12/2018)

Introduction

This document is intended to provide important information to you regarding our working together. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents.

Information about Me

You are free to ask questions at any time about my background, experience and professional orientation. I am a Licensed Marriage and Family Therapist, License number MFC48118.

Fees

The fee for service is $165.00 per individual therapy session and conjoint (marital /family) therapy session.
Individual Sessions and conjoint (marital /family) sessions are 50 minutes in length. Sessions with children (3-16 years) are 45 minutes.
The fee for any court appearance (subpoenaed or expert witness) is $2500.00/day.
Any email correspondence, phone calls, or written documents will be charged accordingly after the first 15 minutes.

Please be sure to provide the information requested on this document, pages 3-5.

I am happy to provide a super-bill for insurance reimbursement purposes upon request.

Fees are payable at the time that services are rendered unless another arrangement is made.

I accept cash, check, or Venmo payments.

Confidentiality
All communications between you and me will be held in strict confidence unless you provide written permission to release information about your treatment (or your child's treatment). If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, I will not disclose information communicated privately to me by one family member, to any other family member without written permission.) There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

If you have been under the care of or are currently seeing another therapist for other issues a release of information (ROI) ***may*** *be requested. If you are currently under the care of an individual therapist and are participating in group therapy under my care a release of information* ***will*** *be requested.*

Minors and Confidentiality
Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, I, in the exercise of my professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist. With patients under the age of 12, I generally provide a brief email update following each session or every other session and we meet together following every 5 to 6 sessions either adults alone or with the minor. The minor clients know this is the general way I work.

Therapist Communications
I may need to communicate with you by telephone, mail, or other means. Please be sure to inform me if you do not wish to be contacted at a particular time or place, or by a particular means.

My therapist may call me on my cell phone. My cell phone number is:

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My therapist may communicate with me by email. My email address is:

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Telephone, Electronic, and Mail Contact
Your confidentiality is always compromised when communicating by electronic devices (text messages or emails) or mail. Your use of such means of communication with me constitutes implied consent for reciprocal use of electronic and mail communication, including email, text messages, and postal mail or fax. **These are not 100% protected or private means of communication (even if encrypted.).**

By initialing* below, you are agreeing to this form of communication between us.

Your signature at the end of this document and initials here indicate you are agreeing that your confidentiality is not protected when choosing to communicate with me via telephone, electronic devices (including email and text messages), postal mail and faxes.

Please be sure to ask me any questions at all about this prior to initialing and signing this agreement.

***Initials: _________________**

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one or more time/s per week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome.

In order **to cancel or reschedule an appointment, you are expected to notify me at least 24 hours in advance** of your appointment to avoid paying for the missed session.

If you do not provide me with at least 24 hours notice in advance, you are responsible for payment for the missed session.

Initials: ________________

Therapist Availability/Emergencies

Telephone consultations between office visits are welcome. However, I will keep those contacts brief due to the belief that important issues are better addressed within regularly scheduled sessions. Any discussions lasting longer than 15 minutes will require a full session fee. You may leave a message for me at any time on my confidential voicemail. If you wish me to return your call, please be sure to **leave your name and phone number(s**), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours. If you have an urgent need to speak with me, please indicate this in your message and follow any instructions that are provided by my voicemail.

In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

About the Therapy Process
It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my feedback. Due to the varying nature and severity of issues and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result. **I will see you weekly or more frequently if we determine appropriate, however every other week sessions are generally not scheduled.**

Completion of Therapy
The length of your treatment and the timing of the eventual completion of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your ending, in collaboration with me. We will discuss a plan for this as you approach the completion of your treatment goals or a need or desire to make a change.

You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives.

HIPPA Notice
You have been provided with a complete copy of current HIPPA information. Please let me know if you have any questions about this and we can discuss your questions or concerns. By signing this agreement, you are also acknowledging that you have read and understood (and discussed as needed), the HIPPA information given to you.

Your signature indicates that you have read this agreement for services carefully and understand its contents. Please ask me to address any questions or concerns that you have about this information before you sign.

Date: ______________________________

Printed Name/s and Signature/s of Patient/s

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