INFORMED CONSENT FOR PSYCHOTHERAPY

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the *Health Insurance Portability and Accountability Act (HIPAA)*, a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. **When you sign this document, it will represent an agreement between us.** We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Psychotherapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a patient in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. The risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Psychotherapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, and increased skills for managing stress and resolutions to specific problems. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will provide you with a referral(s) to set up a meeting with another mental health professional for a second opinion.

CONFIDENTIALITY

It is my ethical responsibility and professional duty to safeguard you from unauthorized disclosure of information given in our therapeutic relationship. I will not disclose any information about you, or the fact that you are my patient, without your written permission.

However, there are important exceptions to this rule of confidentiality. I may use or disclose records or other information about you without your consent or authorization in the following circumstances:

1. When you present with or disclose a serious threat of danger to yourself or others;
2. When you present with or disclose a serious threat of danger to the property of others;
3. When there is a reasonable suspicion of abuse or neglect of a child, older adult (age 65+), or dependent or disabled adult;
4. When ordered by a court to make records available through a lawfully issued subpoena.

Additional exceptions to confidentiality apply to records of treatment for children and adolescents (under age 18). In mental health treatment, the parent or guardian holds the legal privilege regarding release of information.

PARENTS & MINORS
While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 13 and older, I request an agreement between the patient and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised. The **Adolescent Informed Consent Form** will need to be signed by both adolescent and parents.

If you are involved in domestic litigation or become a party to a divorce or custody action, you agree that you will NOT call me to court to testify. Courts appoint professionals who have had no prior contact with the family to conduct custody evaluations and to make recommendations to the Court. As the therapist, it is my role to provide treatment and not to make recommendations to courts in domestic matters. It is my policy NOT to testify in such cases, because experience has shown that the professional relationship is often harmed when therapists testify in divorce and custody cases.

TELEHEALTH
Telehealth includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Telehealth or telephonic and virtual communications allow accessibility for patients to receive mental health care remotely. The confidentiality of your health care information and your patient's rights to your medical information shall apply to telehealth interactions. An additional informed consent procedure for telehealth will be completed verbally and in writing prior to the beginning of treatment via telehealth. The **Informed Consent Form for Telehealth** will need to be completed and signed.

ELECTRONIC COMMUNICATION
Electronic communication (e.g., emails, text messages, facsimile, social media) is not a secure form of communication. In respect for the confidentiality of each patient, I reserve the use of electronic communication for **scheduling purposes only.** The appropriateness of consultations or recommendations may only be determined through therapy sessions, particularly in the events of emergency or time-critical situations. **I will NOT discuss a clinical matter via text message, email, or social media platform**. I do not communicate with any of my patients through social media platforms. If I receive a request to connect with a patient via social media, I will decline the request. If I discover that I have accidentally established a connection with you through social media, I will cancel the relationship immediately. If we inadvertently cross paths via social media, please discuss it with me in your next session.

I will take the necessary precautions to safeguard and protect your privacy. Please wait to discuss clinical concerns with me via phone or in your next session. **Do NOT contact me via text message or email if you are in crisis.** If you are in imminent crisis, call me immediately, go to your Local Hospital Emergency Room, or call 911 and ask to speak to the mental health worker on call.

APPOINTMENTS
Appointments will ordinarily be 50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The work and benefits of psychotherapy is dependent on your consistent attendance and active participation in sessions.

The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. **If you miss a session without canceling, or cancel with less than 24-hour notice, my policy is to collect the $50 for each no-show or late cancellation.** It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for this fee.

If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. I reserve the right to discharge you from my practice after two missed appointments. You will be expected to pay any remaining account balance.

PROFESSIONAL FEES

Initial Adult Assessment	$180	(60 minutes)
Individual Adult Therapy Session	$150	(50 minutes)
Initial Child/Adolescent Assessment	$180	(60 minutes)
Child Play Therapy Session	$150	(50 minutes)
Dyadic Play Therapy Session	$150	(50 minutes)
Adolescent Therapy Session	$150	(50 minutes)
Parent Collateral Session	$120	(40 minutes)

Initial Assessment is the first visit that entails gathering information of your history and the need for psychotherapy. *Therapy Sessions* are subsequent visits addressing your needs. *Initial Assessment for child or adolescent* is a two-part process, where the first visit would only include the parent(s) to gather information about the child's developmental history. The subsequent visits may include two separate sessions, with the first part only with the child or adolescent (*Child Play Therapy Session, Adolescent Therapy Session*) and the second half with just the parent (*Parent Collateral Session*). For children, aged 5, *Dyadic Play Therapy* is the recommended approach, which involves a parent's active participation in play with the child during the play therapy session. In the child's treatment, regular parent sessions are vital as they allow a specified time to discuss impressions and recommendations about the child's challenges or progress in treatment.

You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by cash or credit cards. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, I will charge an hourly fee of $150 for other professional services that you may require such as report writing, telephone conversations that last longer than 5 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. The fee will be on a prorated basis (I will break down the hourly cost) for the work completed for periods of less than an hour.

If payments have been delayed for two sessions, I will not schedule subsequent sessions until your balance is paid in full. If payments have not been made for more than 60 days and payment arrangements are not agreed upon, I have the option to use legal means to secure the payment.

COURT TESTIMONY POLICY
If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

In the treatment for the child and their family, it is my policy NOT to become involved in Child Custody evaluations. While I do not underestimate the value or role of mental health professionals may play in helping courts and families reach fair and appropriate decisions in such an important area, I am not set up to conduct such an evaluation.

In the event that you/parent chooses to serve me with a subpoena to appear at and/or testify in court, and/or a deposition, regardless of the nature of the case, you will be expected to pay a flat rate non-refundable fee at the time the subpoena is served, which secures my commitment for half a day. Required additional court time will be billed at an hourly rate. The rates are as follows:

Half day (minimum)	$750
Additional Hours	$175

INSURANCE
In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. I am not a contracted provider for health insurances, therefore, I cannot accept payments directly from health insurance carriers. However, some insurance companies may reimburse part of your therapy expenses if you have out-of-network coverage for behavioral or mental health. Upon request, I can provide you with a receipt that you can include when filing an insurance claim with your insurance company. Out-of-network reimbursement is often contingent on receiving a medical or mental health diagnosis and certain diagnoses may not qualify. I do not accept responsibility for collecting payment from your insurance company and cannot guarantee that you will be reimburse or that you will qualify for a reimbursable diagnosis. Please contact your insurance provider to find out if you have out-of-network coverage and bring any necessary forms to your first appointment.

PROFESSIONAL RECORDS
I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

TERMINATION
Ending of the therapeutic relationship is an important phase in the treatment. The following circumstances may lead to the end of our work together:

1. When you meet your treatment goals and are no longer in need of therapy
2. When you inform me that you would no longer like to participate in therapy at this time
3. When you stop coming to seasons and I close your case

4. When you are not making progress towards your treatment goals and I determine that it may be in your best interest to connect with another therapist
5. When I determined that you would be better served by another therapist who has more knowledge in the areas in which you need assistance

To process the ending of our work together, I will ask that you attend a termination session if possible, to formally review the therapy process and your experiences in the treatment. If you initiated the termination, you can return at any time as long as your account balance is paid in full. I will plan to keep your file with my inactive files, and upon your return, will simply return your case to active status. If I determined that the terminations is warranted, I will provided you with referrals to therapists in the area whom I deem may be best able to assist you.

CONTACTING ME

I am often not immediately available by telephone. I do not answer my phone when I am with patients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and I will return your call within one business day. **If you are in crisis, please indicate so in your voice mail message and I will return your call as soon as possible.** If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, (1) contact the **Kern County Mental Health Crisis Stabilization Unit at (800) 991-5272**, (2) go to your **Local Hospital Emergency Room**, or (3) call **911** and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

CONTACTING YOU

In instances when I will need to contact you between sessions, such as rescheduling an appointment, please provide the phone number(s) below and whether or not I may leave a message:

Home _____ Call: Yes/No Voice Message: Yes/No

Cell _____ Call: Yes/No Voice Message: Yes/No

Work _____ Call: Yes/No Voice Message: Yes/No

In instances when I may need to send you a mail, please provide the addresses where I may contact you via mail:

Home: _____

Other Mailing Address: _____

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with patients or with former patients.

CONSENT TO PSYCHOTHERAPY

You have been provided with a copy of that document and have been given the opportunity to discuss your concerns and need for clarifications. Please remember that you may reopen the conversation at any time during our work together.

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to abide by its terms during the course of our professional relationship.

_____
Patient's Signature

_____
Patient's Printed Name

Date _____

_____
Parent's Signature (If patient is under 18)

_____
Parent's Printed Name

_____
Date

_____
Parent's Signature (If patient is under 18)

_____
Parent's Printed Name

_____
Date

_____
Psychologist's Signature

_____
Date