Informed Consent & Agreement for Services

This document is intended to provide you important information regarding your treatment. Please read it entirely and carefully and be sure to ask me any questions you may have regarding its contents.

Information about Your Therapist

I am a licensed Marriage, Family Therapist with certification in EMDR I & II, Somatic Experiencing and am a Certified Bioenergetic Therapist (CBT). Professional organizations of which I am a member are California Association of Marriage, Family Therapists (CAMFT), American Association of Marriage, Family Therapists (AAMFT); San Diego North County CAMFT (SDNC-CAMFT); International Institute of Bioenergetic Analysis (IIBA); Southern California Institute for Bioenergetic Analysis (SCIBA). Please feel free to ask me questions regarding my education, specializations, experience and professional orientation.

Fees and Insurance

My professional fee has already been discussed with you, as well as how arrangements may be made for payment. A therapeutic hour is 50 minutes in length and fees are payable at the time services are rendered. If insurance will be involved in your payment, then I require your insurance information, and your signature to correspond with your insurance carrier. Insurance plans determine the co-payment and you have confirmed that with me. Please be aware that insurance plans generally limit coverage to certain diagnosable mental conditions and you are responsible for verifying and understanding the limits of your insurance coverage. Although I am happy to bill for reimbursement, I cannot guarantee whether your insurance will provide payment for the services provided to you. You are responsible for your fee and shall be held liable for any unpaid for billed services should your insurance company fail to cover the professional services provided.

Confidentiality

All communications between you and I will be held in strict confidence with the following exceptions:

1. You have signed an authorization allowing me to disclose information
2. You are in present danger of harming yourself, or committing physical violence to another person
3. You are in court ordered therapy; or your records are petitioned by the court
4. There is an issue of child, elder, or dependent adult abuse
5. 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, 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 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.)

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Sometimes, 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, I would appreciate the courtesy of twenty-four hours notice; otherwise you will be charged your customary fee for that session, barring emergencies of course.

Therapist Availability/Emergencies/General Policies
I would be happy to respond to any questions or needs you may have in between visits and during my normal working hours. However, I will attempt to keep these contacts brief as most important issues are better addressed within the context of a regular face-to-face session. I check my voice mail several times throughout the day and will return your call as soon as possible. However, if you should have a mental health emergency and are unable to reach me, please call 911. I am in the office Monday through Thursday and Friday until 1:00pm.

About the Therapy Process
It is my intention to provide services that will assist you in reaching your goals. Based upon the information you share, I will provide recommendations to you regarding your treatment and you have the right to agree or disagree with my recommendations. I believe that therapists and clients are partners in the therapeutic process. Periodically, I will provide feedback to you regarding your progress and invite your participation in this discussion. Due to the varying nature and severity of problems and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy
The length of your treatment and the timing of the eventual termination 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 termination, in collaboration with me. We will discuss a plan for termination as you approach the completion of your treatment goals.

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. These alternatives may include, among other possibilities, referrals, changing your treatment plan, or terminating your therapy.

Your signature indicates that you have read this agreement carefully and understand its contents. You are also agreeing to having read my “Privacy Practices” as they pertain to HIPPA requirements. Please ask me to address any questions or concerns that you have about this information before you sign!

I, _____ agree to these conditions.
Name of Client (Please Print)

_____ _____
Signature of Client Date

_____ _____
Signature of Therapist Date

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