Client Informed Consent for Treatment

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

Professional Information:
I have a Master's of Arts degree in Clinical Psychology. I am licensed to practice in the State of California by the Board of Behavioral Sciences as a Marriage and Family Therapist (MFT). I am a member of the California Association of Marriage and Family Therapists (CAMFT). In addition, I hold a grief and loss counseling certification; certified Prepare/Enrich facilitator for couples counseling; Level I & II Gottman Method couples counseling; advanced training in anger management; as well as staying current through continuing education units. If you have any questions about my background or experience, please ask.

Fees:
The fee for service is: $_____ per 50 minute session for individuals and couples. Fees are payable at the time that services are rendered.

If for some reason you find that you are unable to continue paying for your therapy, please inform me and I will help you consider any options that may be available to you at that time.

Appointment Scheduling and Cancellation Policies:
Sessions are typically scheduled weekly or bi-weekly (depending on need). Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, kindly notify me at least 24 hrs. in advance of your appointment. ***If you do not provide me with at least 24 hours notice in advance, you are responsible for payment for the missed session.***

*Please initial here to indicate your agreement with the fees, scheduling, and cancellation policies*_____

Confidentiality:
All communications made in session will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in couples 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. I maintain a "no secrets" policy with couples therapy. This means that if you participate in couples

therapy, I am permitted, at my discretion, to use information obtained in an individual session that you may have had with me, when working with other members of your family. However, individual therapy may be an option if a secret needs to be kept for safety reasons.

Exceptions to Confidentiality

Therapists are required to report instances of suspected child or elder abuse. In addition, therapists may be required or permitted to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself.

Minors and Confidentiality:

Communications between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are encouraged to be involved in their treatment. Consequently, I may discuss the treatment progress of a minor client with the parent or caretaker, but not details that would decrease trust between the minor and me. Minor clients and their parents are urged to discuss any questions or concerns that they have on this topic.

Therapist Availability/Emergencies:

Telephone consultations between office visits are welcome. However, I will attempt to keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions.

You may leave a message for me at any time on my confidential voicemail at (949) 613-0899. Non-urgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours. If you have a medical or psychiatric emergency, please call 911.

I may need to communicate with you by telephone, mail, or other means. Please indicate your preferred telephone number and email listed below. Please inform me if communications should not be conducted at a particular time, place, or particular means (i.e. home phone, work phone, etc.). It is very important to be aware that computers, e-mail and cell phone communication can be relatively easy to access by unauthorized individuals and, hence, can compromise the privacy and confidentiality of such communication. E-mails in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them.

Preferred telephone number: _____

Preferred email address: _____

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 clients are partners in the therapeutic process. Remember, therapy is a service that you purchase, and if you are not happy with the services received, it is your responsibility to make that known so we can discuss any hindrances to your progress. I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Participation in therapy does involve some risks, including the possible experience of intense feelings such as sadness, anger, fear, and guilt. Please remember that these experiences are natural and normal and an important part of the therapy process. Sometimes during therapy clients choose to make major life decisions, including decisions regarding family, relationships, employment, and lifestyles. Due to the varying nature and severity of problems and the individuality of each client, I am unable to predict the length of your therapy or 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 myself. I will discuss a plan for termination with you 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 you or I may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

I look forward to our continued meetings, to learning more about you and your hopes and aspirations, and to helping you refine them and make them a reality.

_____ _____

Client's Printed Name Signature Date

_____

Therapist's Signature Date