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**Informed Consent for Therapy Services – Adult**

**THERAPIST-CLIENT SERVICE AGREEMENT**

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 also 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: RIGHTS AND RESPONSIBILITIES, RISKS AND BENEFITS**
Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client 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. Psychotherapy has been shown to have benefits for individuals who undertake it.  Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems.  But, there are no guarantees about what will happen.

Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, fear, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. There may be times in which the therapist may challenge patient’s perceptions and assumptions, and offer different perspectives. The issues presented by patients might result in unintended outcomes, including changes in personal relationships. Patients should be aware that any decisions about the status of his/her personal relationships are the responsibility of patients. During the therapy process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change also might be easy and swift at times, but might also be slow and frustrating. Patients should address any concerns he or she has regarding progress in therapy with therapist. Know also that 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, we will discuss what our work might include. Throughout this process, we will discuss your treatment goals. 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 be happy to help you set up a meeting with another mental health professional for a second opinion.

**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. Sessions longer than 50 minutes are charged for the additional time. 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 your payment [unless we both agree that you were unable to attend due to circumstances beyond your control]. 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.

**PROFESSIONAL FEES**
My regular fee is $250. I reserve the right to periodically adjust this fee. Patients will be notified of any fee adjustments 30 days in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payers, or by agreement with Therapist.

From time to time, upon Patient’s request, we may engage in telephone contact for purposes other than scheduling. Patient is responsible for payment of the agreed upon fee for any telephone calls longer than five minutes. In a addition, from time to time, I may engage in telephone contact with third parties at Patient’s request and with Patient’s advance written authorization. Non-psychotherapeutic services such as consultations with other professionals, preparation of letters, reports, special forms, or court time, etc, are billed at $250/hour. Patient is expected to pay for services at the time services are rendered.

 I also maintain a few slots in my schedule for clients in financial need. Those clients are offered a sliding scale down to $170. You are responsible for evaluating if you are able to afford the full fee, or if you would like to take a sliding scale slot, and what rate you think you can pay, between $170 and $250. I don’t not require you to provide any information about your finances to justify this choice, I trust you to make a decision that feels right for you. If your financial situation changes I request that you begin to pay the full regular rate in order to make a sliding scale slot available to someone else. Every 3 months, I will ask you to re-evaluate whether or not you should be paying a sliding scale slot.

You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check or cash. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. 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, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 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. 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.

**PROFESSIONAL CONSULTATION**

The professional consultation is an important component of a healthy psychotherapy practice. As such, therapists regularly participate in clinical, ethical, and legal consultations with the individual and/or group supervision. During such consultations, therapists will not reveal any personally identifying information regarding patients unless it involves issues of safety to patients.

**PROFESSIONAL RECORDS**
By law, therapists are required to keep appropriate records of the psychological services that they provide. Such records are maintained in a secure location in the office and are the sole property of the therapist. Therapists will not alter his/her normal record keeping process at the request of any patient for any reason. These notes will contain what has actually transpired in sessions, and any interpretations or recommendations will not be provided. Our focus will be on your therapeutic process. If you are planning on using the information collected in sessions for legal proceedings of any kind, I want you to know that my process notes are kept to a minimum. Relying on me for content information is not advisable. I work with your ongoing process in the here and now. This does not translate well to a criminal or civil justice system, where accurate information is essential.

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. Should you request a copy of therapy records, such a request must be made in writing. Therapist reserves the right under California law, to provide patient with a treatment summary in lieu of actual records. Therapists also reserve the right to refuse to produce a copy of the records under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. 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. Therapists will maintain patients records for seven years following termination of therapy. After seven years, patient records will be destroyed in a manner that preserves patient confidentiality. Our primary role is to offer you psychotherapeutic and counseling services.

**CONFIDENTIALITY**

The information disclosed by patients is generally confidential and will not be released to any third party without written authorization from patients, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, reporting child, elder, and dependent adult abuse, or when a patient makes a serious threat of violence towards a reasonably identifiable victim or when a patient is dangerous to him or herself or the person or property of another. Minors above the age of twelve have the right to confidentiality unless they are perceived as harmful to themselves or others and can, under certain conditions, participate in therapy without parental consent. Patient realizes that the therapist is not able to protect the confidentiality of email. You may have as access to information in your file upon written request. You may rescind your release of confidentiality in writing at any time. Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient and another individual, or entity, are parties. Therapist has a policy of not communicating with Patient’s attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient’s legal matters. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed or ordered by a court of law to appear as a witness in an action involving Patient, Patient agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which therapist has made him or herself available for such an appearance.

**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 14 and older, I request an agreement between the client 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, 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.

**CONTACTING ME**
I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two. 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 Santa Clara County Mental Health at 1075 E Santa Clara St, San Jose, CA 95116 or call (408) 792-2100), 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.

**Psychotherapist/Patient Privilege**

The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between the Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient’s behalf until instructed, in writing, to do otherwise by a court of law. Patient should be aware that he/she might be waiving the psychotherapist-patient privilege if he or she makes his or her mental or emotional state an issue in a legal proceeding. Patient should address any concerns he or she might have regarding the psychotherapist-patient privilege with his or her attorney.

**TERMINATION OF THERAPY**

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflict of interest, failure to participate in therapy, Patient’s needs are outside of Therapist’s scope of competence or practice, or patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party’s decision to terminate therapy, Therapist will generally recommend that Patient participate in at least one, or possible more, termination sessions. The sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to the Patient.

**OTHER RIGHTS**
If you are unhappy with what is happening in therapy, I hope you will 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 clients or with former clients.

**CONSENT TO PSYCHOTHERAPY**
Your signature below indicates that you have read and fully understand this Agreement and the Notice of Privacy Practices, and agree to their terms. Your signature indicates that you have had any questions or concerns in regards to the terms and conditions herein addressed to your satisfaction. Your signature indicates that you agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with therapist. Moreover, you agree to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complication whatsoever. You understand that you are financially responsible to Therapist for all charges, including unpaid charges by any other third-party payer.

Signature of Patient or Personal Representative

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Printed Name of Patient or Personal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative’s Authority: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_