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Informed Consent

Psychotherapy can have benefits and risks. The majority of individuals who obtain psychotherapy benefit from the process. Psychotherapy can allow you to better understand what you are feeling and thinking, find new ways for dealing with problems, experience more satisfying intimate relationships, and be more effective in recognizing and meeting your needs, desires, and aspirations. Such changes can reduce stress, allowing you to feel more alive and yourself.

However, therapy is a joint effort. Progress varies depending on the particular problems being addressed, motivation, effort, and other life circumstances such as interactions with family, friends, and others. The length of treatment varies depending upon the nature and intensity of the problems as well as the preceding factors. While the course of therapy is expected to be helpful, it may at times be difficult and uncomfortable. You may experience unwanted feelings such as unhappiness, anger, guilt, or frustration. These are a natural part of the therapy process and often provide the basis for change. You may find your relationship with me to be a source of strong feelings, some of them painful at times. This is a normal part of psychotherapy, and we will work through it together.

My goal is to create a relationship with you in which you feel comfortable sharing your concerns with me and that we can work to resolve any issues that might arise in our relationship. However, I also want you to know that should you need to file a formal complaint about the services you receive from me, the Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Confidentiality

Confidentiality is an important part of psychotherapy. I cannot disclose anything about you or your treatment to anyone else, unless you specifically authorize me to do so. However, California state law requires certain exceptions to the confidentiality rule:

a) If a court of law issues a legitimate subpoena regarding your records.
b) If you are gravely disabled, unable to provide food, shelter or clothing for yourself.
c) Circumstances involving child abuse (physical, emotional or sexual abuse of children, including the downloading of child pornography) as well as elder and dependent adult abuse.
d) If you present a serious threat of harming yourself or others.

In the latter three cases, I am required by law to inform potential victims and legal authorities so that protective measures can be taken. In the case of imminent risk of suicide, I may need to contact your family or other emergency contacts, hospital staff, or first responders.

Privacy

If we see each other accidentally outside the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost important to me. However, if you acknowledge me first, I will be more than happy to speak briefly with you and not engage in any lengthy discussion in public or outside the therapy office. If I am with others, I will not introduce you or identify you as my patient. Furthermore, I will not friend you on social media or respond to any reviews published publically online to protect your privacy

Fees

My fee is $200 per a 50-minute session. If you are paying a reduced fee due to financial constraints, you are responsible for letting me know of any change in your financial situation that would make it possible for you to increase the fee you pay for therapy. Fees are typically subject to change annualy.

Insurance

I do not bill insurance companies directly and I am not a provider for any HMO or PPO plans. However, if you have health insurance that covers mental health services, I can provide you with a statement of fees and services that you can submit directly to your insurance company for reimbursement. If you request a super bill, I am required to provide a diagnosis that becomes part of your medical record. You will still be responsible for paying your fee at each session.

Disclosure of confidential information may be required by your health insurance carrier in order for you to obtain authorization for your visits or to process your claims. In such an instance, I will ask you to sign a release of information form.

No Surprise Act and Good Faith Estimate

Although my fees are transparent and payments are made at the end of each session, I am required by new federal law as of 1/2022 to articulate the estimated cost to you annually. You have the right to receive a "Good Faith Estimate" explaining how much your medical and mental health care will cost. Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services. You can ask me, and any other provider you choose, for a Good Faith Estimate before you schedule a service. If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit https://www.cms.gov/nosurprises.

A typical Good Faith Estimate will include your name, date of birth, a diagnosis code and an estimate for the cost of your sessions for the year. For example: I anticipate your treatment will require weekly 50-minute psychotherapy sessions throughout the next 12 months at [insert fee per session] per session for a total of [x weeks] taking into consideration vacations, holidays, emergencies and sick time for an estimated total of [fee per session] x [number of weeks].

Cancellation Policy Charges & Time Off

In the event that you need to cancel or change an appointment, please give as much notice as possible. Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum advance notice of 48 hours is required. Your full fee will be charged for sessions missed without such notification, unless we are able to reschedule **within the same week** as the cancellation.

If you consent to 3 or more regularly scheduled sessions per week, you are responsible for paying to reserve your slot in the event you are absent. You will not be charged for sessions where I am away or I cancel.

Because therapy is a weekly commitment, I cannot hold your spot(s) if you are away for more than 2 weeks. You are responsible for paying to reserve your spot(s) if you plan to return to therapy beyond 2 weeks. In some cases of extended absence, termination may be discussed.

Cancellation Policy Charges & Time Off (continued)

I am away from the office about 6-8 weeks in the year and will tell you at least two weeks in advance of any planned absences. I will give you the contact information of a therapist who will be available to you during the time I am away.

Phone Contact and Emergency Situations

You may leave a message for me at any time on my confidential voicemail. If would like 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 within two business days. I do not receive or return calls between the hours of 8:00PM and 8:00AM on weekdays, or on the weekends. If you have an urgent need to speak with me, please indicate that fact in your message.

In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance or go to the nearest hospital emergency room. Please also leave me a message at 510-859-7912 and I will call you back as soon as I can. Other resources when you are in urgent need of support include Alameda County's Crisis Support Services Line at 1-800- 309-2131, Berkeley Mobile Crisis 510-981-5900 (if you are a Berkeley or Albany resident) and the National Suicide Prevention Lifeline at 1-800-273-8255.

Telehealth

You have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of your medical information for in-person psychotherapy. Any information disclosed by you during the course of your therapy, therefore, is generally confidential. There are, by law, exceptions under the same laws for in-person psychotherapy see above section on Confidentiality. The dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without your written consent. There are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In the event we are disconnected, I will reconnect with you by the same method and as a last resort call, text or email you to acknowledge the disconnection and provide alternate ways to make up the session. I will notify you if I believe you would be better served by in-person treatment and provide referrals to a therapist in your geographic area if you are out of the immediate area.

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 for us to plan the end of treatment collaboratively, but 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. Treatment alternatives may include, among other possibilities, changing your treatment plan, referral for adjunct services such as medication management, or terminating your therapy.

☐ I have read this Informed Consent statement and have asked all questions to make an informed decision. My signature indicates that I agree to abide by its terms during our professional relationship.

Signature:_____ Today's Date:_____

Full Name:_____

Preferred pronouns: _____ Date of Birth:_____

Address:_____ Phone Number(s):_____

_____ Email: _____

☐ OK to send mail to this address ☐ OK to leave voicemail ☐ OK to text message ☐ OK to email

Emergency Contact Person:_____ _____
(name) (relationship)

_____
(contact person's phone number)

ONLY check if needed: ☐ Superbill (monthly) ☐ HSA receipt (monthly)

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