CONSENT FOR TREATMENT

Informed Consent: I consent to treatment for myself, my child or dependent, which may include psychotherapy and/or psychological testing and, if required, referral for psychotropic medication(s) or other service beyond the scope of psychotherapeutic practice. My therapist has the sole discretion to suspend or terminate treatment, pursuant to the ethical guidelines governing psychological care.

Confidentiality: Information disclosed within sessions is confidential and may not be revealed to anyone unless under one of the following circumstances: where there is reasonable suspicion of child/elder abuse or neglect; when there is reasonable suspicion of self-harm or suicide threat; and, when there is reasonable suspicion of causing serious harm or death to someone else who can be identified. I also understand that if subpoenaed by a judge my therapist may be compelled to surrender written records regarding treatment goals and progress.

Treatment: Services are provided by therapists who are licensed through the California Board of Behavioral Sciences. Services provided by interns or paraprofessionals are required to be supervised by a licensed professional. If I am seen by an intern or paraprofessional my case will be discussed during supervision, the content which will remain confidential. Any questions or concerns I may have may be addressed with my intern or paraprofessional's supervisor. If I or my child/dependent is under the age of 18, I understand that parents/legal guardians have the right to be informed of psychological condition and therapeutic goals and progress.

Timeliness: The therapist's schedule is designed to accommodate specific time-limited sessions (e.g. 50 minute individual session) throughout the day. I understand not to expect more or less time if time modification has not been previously arranged. The therapist cannot make up time if I am late for my appointment.

Cancellation and Attendance: Since appointment scheduling involves the reservation of time specifically for me, a minimum of 24-hour notice is required for rescheduling or canceling an appointment. If I miss more than one appointment without calling to reschedule or cancel 24 hours in advance, I understand that I may be suspended or terminated as a client. I understand that I can be charged $50 for a session that is missed or canceled with less than 24-hour notice.

Payment for Services: I understand that the fee agreement is legally binding contract and that I am under obligation to pay for services provided to me at the time of the session or prior to, and that the fee agreement is valid while receiving services and may be renegotiated pursuant to business cost increases. I understand that failure to pay for services rendered within the negotiated time frame may result in legal action.

To be completed by Therapist: Fee for services is $_____ per hour. ☐ Private/PPO ☐ Copay

Emergency Procedures: While therapists frequently access voicemail, I understand that I should not rely on reaching my therapist for emergency situations. If I have a medical or psychological emergency, I am aware that I should contact my local hospital, police department, or dial 911.

Social Media: Due to the importance of your confidentiality and the importance of minimizing dual relationship, I will not personally accept invitations via social networking sites.

Telephone and Electronic Services: In order to ensure private, confidential and HIPAA compliant communication with my clients, I encourage clients to contact their providers via telephone. However, if you need to contact me via electronic mail, please be aware that email is not a secure way to contact me and I recommend limiting correspondence to administrative issues such as appointments or billing. If you need to discuss any clinical matters, please feel free to call so we can discuss it on the phone or wait to discuss your concerns during your therapy session. If I choose to have online therapy, my signature below acknowledges that I understand the limits of security using Skype. Electronic services may be updated to ensure more security for clients.

Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. My signature below acknowledges agreement to the "Provider-Patient Arbitration Agreement" which is available upon request.

I have read, understand, and accept the foregoing policies and by my signature below acknowledge both agreement and receipt.

Client Signature

Printed Name	Signature	Date

Parent or Legal Guardian Signature(s)

Printed Name	Signature	Date

Printed Name	Signature	Date