INSERT LOGO/LETTERHEAD HERE

**Informed Consent for Counseling Services**

Please read this document carefully in its entirety and ask any questions you have about the content. When you sign this document, it will represent an agreement between us.

CREDENTIALS: I hold a Master’s degree in School Psychology and am Licensed as an Educational Psychologist by the California Board of Behavioral Sciences (License #\_\_\_\_\_)

PRACTICE STRUCTURE: I am in independent practice and am not affiliated with any other individual or practice. My professional records are securely maintained and can only be shared or accessed with your specific written permission.

WHAT IS COUNSELING? The purpose of counseling is to work on specific goals related to improving your overall mental health. Sessions may be individual, group, or family focused and typically last 45-50 minutes.

FEES AND PAYMENT: Counseling fees are $100 per session. Payment can be made via credit card, check, or Venmo.

CANCELLATIONS/NO SHOWS: No fee will be collected for cancellations made with 24 or more hours notice. Cancellations with less than 24 hours notice will be subject to a $25 fee. No show appointments will be subject to the $100 session fee.

INSURANCE INFORMATION: I am an out-of-network provider. This means that I am not a member of a provider network for any managed care plans. Your insurance plan may or may not cover visits to an out-of-network provider. You are responsible for payment of all charges, submission of bills to your insurance company, obtaining information about your coverage and making certain that we are both aware of any authorization requirements for psychological testing. I will provide you with a Statement for Reimbursement/Superbill should you choose to submit to your insurance company for reimbursement. Many insurance plans cover psychological services and many require the member to make a telephone call before an initial appointment. If you are interested in submitting for reimbursement, I recommend that you contact your insurance company to request information about out-of-network benefits for psychological consultation and testing prior to the first appointment. If you call your insurance company, let them know that you are calling for counseling. They may ask you for CPT Codes. These are listed below:

90834, Psychotherapy

If your insurance company authorizes the reimbursement I am not in control of how quickly they will process this request.

CONFIDENTIALITY: All information disclosed in sessions is confidential and may not be revealed to anyone without the client or guardian’s written permission, except where disclosure is mandated or allowed by law. Such situations include the following:

* The evaluator believes that a client may be a danger to themself, another, or another’s property and that disclosure is necessary to prevent the danger. In the case of danger to another, the psychologist is required to notify the police and take reasonable steps to warn the intended victim.
* There is a reasonable suspicion of actual or potential child abuse (emotional, physical, sexual) or neglect involving the client, or someone known by the client.
* There is a reasonable suspicion of neglect or abuse of a dependent adult or elderly person.
* A client is “gravely disabled” (i.e., is unable to take care of basic needs such as feeding, self-grooming, getting home safely).
* A valid court order (legal subpoena) is issued for a client’s files.

**Patient’s Bill of Rights**

* Request and receive full information about the psychologist’s professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.
* Have written information about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in cases of vacation and emergencies), and cancellation policies before beginning therapy.
* Receive respectful treatment that will be helpful to you.
* A safe environment, free from sexual, physical, and emotional abuse.
* Ask questions about your therapy.
* Refuse to answer any questions or disclose any information you choose not to reveal.
* Request that the therapist inform you of your progress.
* Know the limitations of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
* Know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case.
* Refuse a particular type of treatment or end treatment without obligation or harassment.
* Refuse electronic recording (but you may request it if you wish).
* Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and type of treatment.

CONTACT: The best way to contact the evaluator is through the confidential voice mail answering system. Please be aware that I do not answer calls when I am in appointments, but I check voice mail often. I will make every effort to return your call within 24-48 hours, except for weekends and holidays, but cannot guarantee that this is always possible.

If you are facing a psychological or medical emergency call 911.

AGREEMENT OF INFORMED CONSENT: Your signature below indicates that you have read the information in this agreement and agree to abide by its terms during our professional relationship. By your signature below, you indicate that:

* You have been informed of and understand the type of services to be provided.
* You have been informed of the limits of confidentiality.
* You understand and agree to the payment and cancellation policies.
* You accept full responsibility for all fees incurred in participation in counseling as spelled out in the agreement.
* You understand that, if you are provided with a digital copy of the report, you are not permitted to make any changes to the report.

Name of individual receiving counseling support: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date