***Kimberly A Gaines Counseling***

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*Murrieta, CA 92563*

**INFORMED CONSENT**

Introduction

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

The Therapy Process

Participating in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that have led you to seek therapy. Working toward these benefits, however, requires effort on your part and may result in you experiencing considerable discomfort. Change will sometimes be easy and swift, but more often it will be slow and frustrating. Remembering unpleasant events and resolving them through therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended. When working with children, behavioral symptoms often increase before positive changes occur. As part of the therapeutic process, I may use several techniques including art, play, relaxation, and homework assignments. 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 patients are partners in the therapeutic process. You have the right to agree or disagree with my feedback. Due to the varying nature and severity of issues and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

Client’s Rights and Confidentiality

You have the right to a confidential therapeutic relationship. Within certain legal limits (see #3 below), information revealed by you during the course of therapy will be kept completely confidential and will not be revealed to any person without your written permission.

1. You have the right to know the content of your records at any time and I have the right to provide you with the complete records or a summary of their content.
2. If you ask me, I can release any part of your records on file to any person you specify. I will tell you when you make your request whether or not releasing that information to that agency or person might be harmful to you at any time.
3. Under certain legally defined situations, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:
	1. If you reveal information about active child abuse or neglect, elder abuse, or dependent physical abuse, I must make a report to protective services. When a perpetrator of child abuse is in contact with minors and there is a reasonable suspicion that he/she may still be abusing minors, I must also report that information.
	2. If you seriously threaten harm or death to another person, I am required to warn the intended victim and notify the appropriate law enforcement agencies.
	3. If you are in therapy or being tested due to an order of a court or lawyer, the result of the treatment or tests ordered must be revealed to that court or lawyer.
	4. If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in that subpoena.
	5. If you are in a lawsuit where emotional harm is being claimed, the opposing side may subpoena your therapy records.
4. Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding you or your family members or caregivers.
5. You have the right to ask questions about any of the procedures used in the course of your therapy. I will explain my customary approach and methods to you.
6. Communications between therapists and patients who are minors are confidential. However, parents and other guardians who provide authorization for their child’s treatment are often involved in their treatment. Consequently, I (using professional judgment) may discuss the treatment progress of a minor client with the parent or caretaker.
7. You have the right to choose NOT to receive therapy from me. If you choose this, I will provide you with names of other qualified professionals whose services you might prefer.
8. You have the right to terminate therapy at any time without any financial, legal, or moral obligations other than those you’ve already incurred.
9. I have the right to terminate therapy with you under the following conditions:
	1. When I believe that therapy is no longer beneficial to you.
	2. When I believe that you will be better served by another professional, whom I will recommend. If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified. If I have written consent from you, I will provide that professional with the essential information he or she requests.
	3. When you have not paid for the last two sessions, unless special arrangements have been made.
	4. When you have failed to show up for your last two therapy sessions without a 24-hour notice.

If any of these situations apply, I will send you a certified letter to your address of record to inform you of the decision, and I will give you the names of several therapists for your future counseling needs.

Fees and Insurance

The standard fee for each session is $120, unless other arrangements have been made prior to the start of therapy. Sessions are approximately 45-50 minutes in length. Payment in the form of cash, check, or credit card is required at the time of the therapy appointment, unless other arrangements have been made in advance. You may leave therapy at any time and are only contracting to pay for the completed therapy session or sessions missed without providing a 24-hour notice. Every client must keep an updated Credit Card Authorization on file. The Credit Card Authorization will be utilized for cancellations with less than a 24 hour notice, appointments missed without any notice (no-shows), and insurance refusal to pay for services.

Please inform me if you wish to utilize health insurance to pay for services. If I am a contracted provider for your insurance company, your copayment will be provided by you at the time of service. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. If reimbursement has not been received by your insurance company within 60 days of billing, you will be responsible for the full amount of the bill. This is typically due to a simple delay in processing by the insurance company, but it is ultimately your responsibility to handle any delays or denial of payments by your insurance company. You should be aware that insurance plans generally limit coverage to certain Diagnosable Mental Disorders. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although I will assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you. Clients who have a PPO Insurance Policy, may request from me a Superbill which may be self-submitted by you for reimbursement directly to your insurance company. You also agree that you will pay the standard fees at the time of service, regardless of what reimbursement you may receive from your insurance company at a later date. If for some reason you find that you are unable to continue paying for your therapy, you should inform me. I will help you consider any options that might be available to you, including a fee that is reasonable for both of us.

Dual Relationships

Therapy never involves sexual, business, or any other dual relationships that could impair my objectivity, clinical judgment, therapeutic effectiveness, or anything that could be exploitative in nature. Please discuss this with me if you have questions or concerns.

Clinical Records

I am required to keep appropriate records of the psychological services that I provide. Although psychotherapy often includes discussions of sensitive and private information, normally very brief records are kept noting that you have been here, what was done in session, and a general mention of the topics discussed. You have the right to a copy or summary of your file at any time. You have the right to request that a copy of your file be made available to any other health care provider at your written request. Your records are maintained in a secure location according to HIPAA Standards.

General Office Policies

1. Payment for Services: You are expected to pay for services at the time they are rendered unless other arrangements have been made. I am able to accept payment in the form of cash, check, or credit card. Please notify me if any problem arises regarding your ability to make timely payments.
2. Scheduling: Please schedule appointments either by phone at (951) 821-0557 or in person at the end of each therapy session.
3. Cancellations: Since an appointment reserves time especially for you, a minimum of 24-hour’s notice is required for rescheduling or cancellation of an appointment. The full fee will be changed for sessions missed without such notification and a Credit Card Authorization must be kept on file in order to process this fee should this occur. You may reschedule or cancel appointments by calling (951) 821-0557 or via the contact link on my website at [www.kimberlyagaines.com](http://www.kimberlyagaines.com).
4. Office Hours: My business hours are subject to change at any time, but I typically see clients on Mondays, Wednesdays, & Fridays at various times between 9:00 am & 9:00 pm, depending on client needs & my availability.
5. Office Waiting Area: My office has a lobby that is shared by multiple therapists. When you enter the waiting area, push the call light above my name to alert me of your arrival and I will greet you at your scheduled time.
6. Therapist Availability/Emergencies: Telephone communication between sessions is welcome; however, I will keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions. Any discussions lasting longer that 10 minutes will require a full session fee. You may leave a message for me at any time on my confidential voicemail. If you wish me to return your call, please be sure to leave your name and phone number, along with a brief message and whether or not it is okay to leave a voicemail message back to you should I be unable to reach you. Non-urgent phone calls will be returned during normal work hours within 24 hours. If you have an urgent need to speak with me, please indicate that fact in your message and follow any instructions that are provided by my voicemail. In the event of an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.
7. Email Communications: By nature, email correspondence is NOT confidential. Though Internet security measures can be effective, it is never 100% seal proof. My policy regarding email usage is as follows: Email correspondence with me is NOT secure & it is NOT a substitute for person-to-person therapeutic treatment. Anything stated in an email from you will be discussed in session. Email correspondence is NOT to be used in the case of an emergency to contact me. If you need to contact me with something that demands immediate attention, please do so by voicemail at the following number: (951) 821-0557, call 911, or go to the nearest emergency room. If it becomes necessary, I will terminate treatment if email usage is or becomes inappropriate.

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 me. 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 benefitting from treatment, either of us may elect to initiate a discussion of your treatment alternatives.

Acknowledgment

I have read this information fully and completely, I have discussed any questions I had about the information, and I understand the contents of this Informed Consent. I acknowledge that it is my choice to participate in psychotherapy (or have my child participate). I realize that the outcome of therapy depends upon my personal investment in the therapy process. I have familiarized myself with the fees and charges for services.

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Client’s Name (Printed)

Parent/Guardian’s Name and Relationship to Minor Client (Printed)

Client or Parent/Guardian’s Signature Date

**Please sign the Consent below that applies to you. If there is a minor involved, a Consent to Treat a Minor must be signed.**

**ADULT Consent for Treatment**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize and request Kimberly Gaines, LMFT to carry out therapeutic treatment that is advisable now or during the course of my care as a client. I understand that the purpose of any treatment will be explained to me and be subject to my agreement. I have read and fully understand this Consent for Treatment form.

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Client or Parent/Guardian’s Signature Date

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Therapist’s Signature Date

**Consent to Treat a MINOR**

I generally require the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of a parent or caregiver to give consent for psychotherapy, I will require copies of supporting legal documentation (such as a custody order) prior to the commencement of services. When working with an individual child, I respect his/her right to confidentiality. I will consult with you about your child’s progress. Both parents are entitled to know the nature and progress of their child’s therapeutic services. If I am treating your child in individual sessions, I appreciate you telling me at the beginning of the session whether there have been any unusual happenings since our last session or issues of concern you wish to discuss prior to the child’s session. This interchange must be brief so as not to interfere with the child’s therapy session. If a more extended time is needed, please call for a separate appointment or request a telephone session (see section concerning phone calls). Some children need to know that their parent is present for them in the waiting room and sometimes we involve the parent in a special session. Please inform me where you plan to wait while your child is in session and if your child is under the age of 10, please remain on site during their session. If you do leave, please make sure you get back on time to pick up your child as I cannot be responsible for watching your child between sessions. Children should not be left unsupervised in the office at any time.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as parent/guardian of minor child named \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize and request Kimberly Gaines, LMFT to carry out therapeutic treatment that is advisable now or during the course of his/her care as a client. I understand that the purpose of any treatment will be explained to me and subject to my agreement. I have read and fully understand this Consent to Treat a Minor form.

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Parent/Guardian’s Signature Date

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Parent/Guardian’s Signature Date

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Therapist’s Signature Date

**Consent for COUPLES or FAMILY Therapy**

As a couple/family we agree to engage in therapy which will include both joint and individual sessions. I understand my right to confidentiality in individual sessions, but I am willing to waive this right so that information shared in individual sessions can be shared in joint sessions at the discretion of the therapist. I also understand that my therapist believes that couple/family therapy is most successful when a family is willing to be completely honest with the therapist and with each other. For this reason, my therapist has explained that she is unwilling to collude with secrets. When a family member shares information with the therapist it will be discussed in joint sessions to maintain an atmosphere of openness and honesty. I authorize and request Kimberly Gaines, LMFT to carry out therapeutic treatment that is advisable now or during the course of my care as a client. I understand that the purpose of any treatment will be explained to me and be subject to my agreement. I have read and fully understand this Consent for Treatment form.

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Client or Parent/Guardian’s Signature Date

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Client or Parent/Guardian’s Signature Date

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Therapist’s Signature Date