Balanced
Health and Wellness

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INFORMED CONSENT

Welcome! This document contains important information about my professional services and business policies. Please read it carefully and note any questions you might have so that we can discuss them. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Therapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular issues or concerns you bring to therapy. Your feelings about the therapy or psychologist are very important. I encourage you to discuss any questions, confusion, or frustrations you experience so that they do not become obstacles to your treatment. I believe you are the best authority on whether a treatment relationship will be helpful.

Our first few sessions will involve an evaluation of your needs and problems. By the end of the evaluation, I will be able to offer you some first impressions as to why you are experiencing the problems you have presented and what treatment I would recommend, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have any doubts about continuing, I will be happy to help you set up a meeting with another mental health professional.

BENEFITS AND RISKS

There are both benefits and risks of psychological services. During the course of therapy, it is often the case that you will feel worse before you feel better; this is natural and expected in any healing process.

The ***benefits*** may include reduced stress and anxiety, a decrease in negative thoughts and self-defeating behaviors, improved relationships, increased comfort in social, school and/or family settings, increased self-confidence, and a more hopeful attitude towards life.

The ***risks*** may include recalling or recounting painful memories and experiences, discomfort in analyzing current distress and problems, and the possibility of experiencing strong feelings of sadness, anger, fear or other difficult emotions. As your psychologist, I may from time to time challenge your assumptions or perceptions and offer a different perspective. Changes in your perspective, thoughts, or feelings may have unintended outcomes, including changes in personal relationships.

Personal growth can be difficult and slow or easy and swift. When we sign this agreement together, I commit to helping you through the entire process of therapy. This will mean helping you to achieve the goals you initially state, but also other issues or problems that may arise during our work together that require further exploration and analysis. If this happens, we will work together to revise the goals as appropriate and work towards a satisfactory solution of your problems.

There is no guarantee that therapy will yield any or all the benefits listed above. Neither is there any certainty that the risks listed above will be encountered during our work together. Therapy is an open and dynamic process, and its course is dependent upon our mutual willingness to collaboratively continue the process and, to a certain extent, upon life events that cannot be foreseen.

CONFIDENTIALITY

In general, the privacy of all communication between a patient and a mental health professional is protected by law and I can only release information about our work to others with your written permission. However, there are a few exceptions:

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a *reasonable suspicion* of child, dependent or elder, abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled. Please feel free to ask me if you need further details regarding State mandated or permitted breach of confidentiality.

When Disclosure May Be Required: Disclosure may be required pursuant to a *legal proceeding*. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by me. Disclosure may also be required *in couple and family therapy*, or when different family members are seen individually. When conducting therapy where the unit of treatment is more than one person, confidentiality and privilege do not apply between the couple or among family members. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless I am authorized to do so by <u>all</u> adult members who were part of the treatment (i.e., partner, spouse, parents).

Emergencies: If there is an emergency during our work together, or in the future after termination, where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can, within the limits of the law,

to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the police, hospital or the person whose name you have provided on the intake form.

Confidentiality of E-mail, Cell Phone, Text Messaging and Faxes Communication: It is very important to be aware that e-mail, cell phone (also cordless phones), and text message communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be easily compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can be sent erroneously to the wrong address. Please notify me at the beginning of treatment if you prefer to avoid or limit any of these above forms of communication. **Please do not use e-mail, text message or faxes in emergency situations**.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (i.e. **divorce and custody disputes**, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf, will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Consultation: I consult from time to time with other professionals regarding my clients; however, the client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking action. Considering all the above exclusions, if it is still appropriate, upon your request, I will release information to any agency/person you specify unless I conclude that releasing such information might be harmful in any way. This includes allowing you to see your own medical records.

MEETINGS

Therapy sessions last approximately **60-minutes** and I will try to schedule these meetings at a time that works in your schedule. Since certain times are in greater demand, I would recommend scheduling appointments some time ahead in order to reserve a time that is best for you. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome.

CANCELLATIONS AND LATE ARRIVALS

Since scheduling an appointment involves the reservation of time specifically for you, a **minimum of 24 hours (1 day's) notice is required for re-scheduling or canceling an appointment**. You will be receiving automated reminders 1-2 days in advance and we do require that you respond to these

reminders so that we are assured that you intend on keeping your scheduled appointment. Office policy is to charge a $100 fee to the credit card on file for appointments that are missed without proper notification. This fee is not reimbursable by any insurance you may have **Initial your understanding of this Policy here~ Patient/ Guardian Initials_____ ☐**

Since our time together is reserved for you in 60-minute blocks, if you are late to your session, I will be able to see you for the remainder of the 60 minutes left in your scheduled 60 minutes only. I am not able to give you extra time as this is not fair to other clients who have reserved their time as well and want to utilize their entire 60-minute session. You are still responsible to pay for the entire session as this time was reserved for you whether you are able to use it all or not. If you continue to have a difficult time getting to your session on time, discuss this with me as it may be better to find a time that will work better for you in my schedule. I want you to be able to use all the time reserved for you.

PSYCHOLOGIST AVAILABILITY/ EMERGENCIES

I am available for regularly scheduled appointment times. Dates of vacations and other exceptions will be given out in advance, if possible. You may leave a message for me anytime on the main office phone (949-606-4698). I am available to return messages Monday through Friday, 9 am to 6pm. In the event of an emergency involving a threat to your safety or the safety of others, please call 911, the 24-hour crisis Suicide Prevention Center (877) 727-4747 or go to your nearest emergency room.

DUAL RELATIONSHIPS

A "dual relationship" refers to situations in which the therapist has more than one role with the client. For example, I cannot be your therapist and your friend, cannot hire you or recommend you for anything, cannot accept expensive gifts or anything that might influence how I treat you. This includes "friending" or "following" each other on personal social media pages. I hope our relationship will be warm and close, but it will be about **you** and helping **you.** It is not a mutual relationship in that you will not learn much about me, about my personal life, and you are not responsible for tending to my needs and feelings. If there is a potential dual relationship, it needs to be discussed and evaluated to see if it would be wiser to continue therapy or transfer you to a different therapist. Avoiding dual relationships leaves you freer to be open and honest with me.

TERMINATION OF THERAPY

You may terminate therapy at any time. If is it determined that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include referrals, changing your treatment plan, or terminating your therapy.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____

Signature of Patient (or Guardian) **Date**

_____

Printed Name of Patient (or Guardian)

Statement of the Psychologist. This document was discussed with the client and any questions were discussed. I have assessed the client's mental capacity and found the client capable of giving an informed consent at this time.

Indicate here if you would like a copy of this consent: Yes ☐ No☐

_____ _____

John Misa, Psy.D. (PSY 27380) **Date**

John Misa, PsyD, Lic. PSY27380

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RELEASE OF INFORMATION

I, _____ (patient name), hereby authorize Dr. John Misa to **release information** and/or records pertaining to my evaluation, diagnosis, and/or therapy sessions to (please provide name, address, and phone number):

_____

_____

For the specific purpose of_____

_____

I understand that authorization shall remain valid from the date of my signature below and for one year thereafter ending on: _____

I have been informed that I may only revoke this authorization in writing. I certify that this form has been fully explained to me and that I understand its contents.

_____ _____

Signature of Patient/ Guardian Date of Authorization

_____ _____

John Misa, Psy.D. Date