Please take a few minutes to read these 2 pages (front and back) before we get started.

If you have any questions, feel free to let me know.

Confidentiality: I take your privacy and confidentiality very seriously. All information discussed in sessions is confidential and will not be disclosed to anyone without your written permission except when required by law. Disclosure may legally be required if: 1) there is a reasonable suspicion of child or elder abuse, 2) there is reasonable suspicion that a client presents an imminent danger of violence to others, or 3) a client is likely to harm him/herself unless protective measures are taken. Disclosure may also be required pursuant to legal proceedings or if you file a worker’s compensation claim.

Initials\_\_\_\_\_\_\_

Therapist, Fees, and Insurance: I am Dr. Iris Pachler, Licensed Psychologist PSY26304. My fee is $175 per 53-minute session for adults and $200 per 53-minute session for couples, families, and minors.

If sessions are covered by insurance, I will bill them directly and Client will only be responsible for the co-pay.

There will be a $25 additional fee for any checks that do not clear the bank, and a 20% late charge for fees not paid at the beginning of each session. Any unpaid balances must be cleared prior to scheduling further appointments.

Initials\_\_\_\_\_

Out-of-session Services and Telephone Consultations: Effective consultation or treatment sometimes requires planning or coordination of treatment efforts with others. This is especially common when treating children and may involve communicating with or preparing reports for the child’s school, pediatrician, or other professionals. Similar consultations may also be desirable for some adult clients. Such out-of-session services are billed on a prorated basis of my usual rate. I will advise adult clients or parents of minor prior to engaging in such out-of-service services. These services are payable in advance or upon receipt of invoice.

Telephone consultation with clients, parents, or other collaborating entities in excess of ten minutes will be charged on a prorated basis, with payment due upon receipt of invoice or at our next scheduled session, whichever comes first.

Initials\_\_\_\_\_

Cancellations or Missed Appointments: Since scheduling an appointment means reserving a regular time specifically for you, a minimum of 24 hours is required to reschedule or cancel. If you must cancel please let me know as soon as possible. You can leave a message at any hour, on any day, including weekends at 530-417-5824. If you miss your appointment or cancel it less than 24 hours in advance, you will be billed for that time. Insurance, Victim Witness, and Worker’s Compensation cannot be billed for missed appointments. Therefore, the Client will be responsible to pay for the session at the rate of their private pay fee or the insurance reimbursement rate for the hour.

Initials\_\_\_\_\_

Records and Record Keeping: I will not voluntarily participate in any litigation, or custody dispute in which client and another individual, or entity, are parties. I have a policy of not communicating with a client’s attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in a legal matter unless agreed upon at beginning of the therapeutic relationship. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving a client, the client agrees to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my customary hourly rate of $150.00.

Initials\_\_\_\_\_\_

Consent for Psychological Treatment: By signing this form, you are giving consent for psychological treatment including but not limited to, clinical interview, psychological testing, and psychotherapy as deemed necessary. You are consenting and agreeing only to those mental health services that I am qualified to provide within the scope of my license, certification, and training. You are an active participant in your treatment. You have input regarding your treatment goals and can decline any particular form of treatment about which you are uncomfortable at any time.

Initials\_\_\_\_\_\_\_

Agreed fee for appointments failed or cancelled with less than 24 hours notice\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

So that I know you have read and understood these policies, please sign and print your name and write today’s date on the line below. If you are here for couples or family therapy, please have each family member sign, and if therapy is for a minor child, please provide a signature of the legal guardian. Thank you for taking the time to read this.

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Date Please print your name, then provide your signature

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Date Please print your name, then provide your signature (second family member)

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Date Please print your name, then provide your signature (third family member)