GODMAN PSYCHOLOGICAL SERVICES, P.C.
Helping to navigate the mind
4231 Balboa Avenue #1256
San Diego, CA 92117
T: (619) 785-3665
info@godmanpsych.com

INFORMED CONSENT FOR PSYCHOTHERAPY

Godman Psychological Services' Mission Statement

At Godman Psychological Services, PC, our mission is to provide compassionate, evidence-based mental health care that empowers individuals to achieve emotional well-being and personal growth. We are committed to fostering a supportive and inclusive environment where clients feel heard, valued, and understood. Through expert psychological assessment, therapy, and personalized interventions, we strive to help individuals, families, and communities navigate life's challenges with resilience and confidence. Our goal is to promote lasting positive change by integrating the latest research with a client-centered approach, ensuring every person receives the highest quality of care on their journey to mental wellness.

General Information

The therapeutic relationship is unique, as it is both deeply personal and a professional agreement. Therefore, it is essential for us to establish a clear understanding of how we will work together and what we can expect from each other. This consent form provides a structured framework for our collaboration. If you have any questions, please feel free to discuss them with me.

Our Clinicians

Carolyn Godman, Ph.D., CCHP-MH CA PSY28831/NYS 019200/FL TPPY2883

Nature of Therapy

Psychotherapy is a collaborative process that involves discussing personal experiences, thoughts, and emotions to promote mental and emotional well-being. The effectiveness of therapy depends on your willingness to engage in this process, which may involve exploring difficult or uncomfortable topics. While therapy can lead to positive changes, such as improved coping skills and emotional relief, results cannot be guaranteed.

Confidentiality – (Clinician-Patient Privilege)

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have any or all or portions of such content released to a specifically named person/persons. *Limitations* of such client held privilege of confidentiality exist and are itemized below:

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1. If you threaten or attempt to commit suicide or otherwise conduct yourself in a manner that the clinician has reasonable cause to believe that you are in such a mental or emotional condition as to be dangerous to your person and that disclosure of the communication is necessary to prevent the threatened danger.
2. If your clinician has reasonable cause to believe that you are in such mental or emotional condition as to be dangerous to another person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.
3. If the clinician has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. If the clinician has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, financial, or sexual abuse of an elderly person (65 and older) or dependent adult who is disabled.
5. Suspected neglect of minors or the elderly.
6. Patient-Litigant exceptions: If the issue concerning the mental or emotional condition of the patient in a litigation manner has been tendered by: (a) the patient; (b) any party claiming through or under the patient; Any party claiming as a beneficiary of the patient through a contract to which the patient is or was a party; (c) Plaintiff is parent/ward and brings action for the injury or death of the minor patient.
7. Clinician is appointed by order of a court to examine and/or treat the patient.
8. Clinician's services were sought/obtained to enable or aid anyone to commit or plan to commit a crime or a tort or to escape detection or apprehension aft the commission of a crime or a tort.
9. Communication relevant to an issue of breach, by the clinician or by the patient, of a duty arising out of the clinician-patient relationship.
10. *Additional instances that are exceptions to the clinician-patient privilege can be found in Evidence Code Sections 1016-1025. (e.g. sanity of criminal defendant, parties claiming privilege through deceased patient, and proceeding to establish competence brought by patient.)*

Occasionally your clinician may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

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If you see your clinician accidentally outside of the therapy office, they will not acknowledge you first. Your right to privacy and upholding confidentiality is of the utmost importance to GPS, and your clinician does not wish to jeopardize your privacy. However, if you acknowledge your clinician first, they will speak briefly with you.

Client Responsibilities

- Attend scheduled sessions consistently and on time.
- Actively participate in the therapeutic process.
- Communicate openly about your thoughts, feelings, and concerns.
- Inform your therapist of any changes in medication or significant life events that may impact therapy.
- Refrain from engaging in therapy while under the influence of drugs or alcohol.
- Be open-minded.

Potential Risks and Benefits

While therapy often leads to personal growth, there may be times when discussing painful or distressing experiences causes temporary emotional discomfort. This is a natural part of the process. Benefits may include increased self-awareness, improved relationships, and enhanced coping strategies.

Fees and Payment Policies

- The standard session fee is $225 per 55-minute session.
- Payment is due at the time of service unless other arrangements have been made.
- Cancellations require at least 24 hours' notice; otherwise, you may be charged a late cancellation fee of $100.
- Insurance coverage is the client's responsibility, and any copayments or deductibles must be paid as required.

Clinician emergency or incapacitation

In the event of your clinician's unexpected absence, your clinician maintains a Professional Will that appoints a colleague to make contact with you on their behalf. This colleague is only granted access to your file or contact information in the limited instance that your clinician becomes unexpectedly absent from practice and is unable to make contact with you themselves to arrange for continued care.

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Threats, Harassment, and Intimidation

If you engage in threats, harassment, or intimidation toward your clinician or others in this office, this may be grounds for immediate termination of therapy. You also grant permission for your clinician to share information about any threatening behavior with law enforcement and/or others as they believe necessary to protect their safety and that of others.

Electronic Communication with Clinician

Your phone, video and text communications with your clinician are conducted through HIPAA compliant mediums. While our clinicians try to return messages in a timely manner, Godman Psychological Services, PC, cannot guarantee an immediate response. *Please do not use these methods of communication to request assistance for emergencies. If you experience a mental health crisis, please call 911, go to the nearest emergency room, or contact a crisis hotline such as the National Suicide Prevention Lifeline at **988**.*

Authorization Statement

The Client authorizes Godman Psychological Services, PC, to use and disclose medical information in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Privacy Rule, 45 CFR part 160 and Part 164. These services may include psychological testing, psychotherapy/counseling, rehabilitation service, biofeedback, brain computer interface therapy, medication, case management, laboratory tests, diagnostic procedures, and other appropriate services. These services may be delivered at different locations.

Termination of Therapy

You have the right to end therapy at any time. If you choose to terminate therapy, I recommend discussing your decision during a session to ensure proper closure. I may also terminate therapy if I believe treatment is no longer beneficial or if ethical guidelines require referral to another provider.

Filing a Complaint

If you feel your psychologist has acted illegally, irresponsibly, or unprofessionally may file a complaint with the California Board of Psychology.

How Do I File a Complaint?

- Your complaint may be filed electronically.

- You can call the CA Board of Psychology for a complaint form at (866) 503-3221
- You can download a complaint form for submission by mail available here in Adobe Acrobat format:
  - Download the Consumer Complaint Form and print it.
  - Complete, sign and mail the form to:
    Board Of Psychology
    1625 North Market Street, Suite N-215
    Sacramento CA 95834

If a dispute arises from or relates to this contract or the breach thereof, and if the dispute cannot be settled through direct discussions, the parties agree to endeavor first to settle the dispute by mediation administered by the American Arbitration Association under its Healthcare Payor Provider Mediation Procedures before resorting to arbitration. The parties further agree that any unresolved controversy or claim arising out of or relating to this contract, or breach thereof, shall be settled by arbitration administered by the American Arbitration Association in accordance with its Healthcare Payor Provider Arbitration Rules and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

Claims shall be heard by a single arbitrator, unless the claim amount exceeds 500,000 dollars. The arbitrator(s) shall be familiar with psychological services and treatment. The place of arbitration shall be Monterey County, CA. The arbitration shall be governed by the laws of the State of California. The arbitration administration will proceed under the Desk/Telephonic Track.

Depositions shall be limited to a maximum of 3 per party and shall be held within 10 days. Additional depositions may be scheduled only with the permission of the arbitrators, and for good cause shown. Each deposition shall be limited to a maximum of 3 hours. The arbitration will be based on the submission of documents and there shall be no in-person or oral hearing. The arbitrators will have no authority to award punitive or other damages not measured by the prevailing party's actual damages, except as may be required by statute. The arbitrator(s) shall not award consequential damages in any arbitration initiated under this section. Any award in an arbitration initiated under this clause shall be limited to monetary damages and shall include no injunction or direction to any party other than the direction to pay a monetary amount. Each party shall bear its own costs and expenses and an equal share of the arbitrators' and administrative fees of arbitration. The award of the arbitrators shall be accompanied by a reasoned opinion.

The arbitrator's award shall be accompanied by findings of fact and conclusions of law. Except as may be required by law, neither a party nor an arbitrator may disclose the existence, content, or

results of any arbitration hereunder without the prior written consent of both parties. Notwithstanding any language to the contrary in the contract documents, the parties hereby agree: that the Underlying Award may be appealed pursuant to the AAA's Optional Appellate Arbitration Rules ("Appellate Rules"); that the Underlying Award rendered by the arbitrator(s) shall, at a minimum, be a reasoned award; and that the Underlying Award shall not be considered final until after the time for filing the notice of appeal pursuant to the Appellate Rules has expired. Appeals must be initiated within thirty (30) days of receipt of an Underlying Award, as defined by Rule A-3 of the Appellate Rules, by filing a Notice of Appeal with any AAA office. Following the appeal process the decision rendered by the appeal tribunal may be entered in any court having jurisdiction thereof.

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BY SIGNING BELOW I AM AGREEING:

- That I have read and understood, or had this form read and/or had this form explained to me and understand its content.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
- That I consent to the use of telehealth/telemedicine if the clinician determines that the benefit or service is clinically appropriate to be provided.

CLIENT NAME: _____ CLIENT DOB: _____

Signature of Client:_____ Date:_____

Signature of Parent/Guardian:_____ Date:_____

Relationship to Client:_____

Clinician Name: _____ Date:_____

Clinician Signature: _____