

Informed Consent

Therapy:

Therapy is designed to help clients of all ages understand how their feelings and thoughts affect the ways they act, react, and relate to others. Whether or not therapy works depends a great deal on the client's willingness and ability to experience all relationships deeply, especially the therapeutic relationship. Clients have a unique opportunity to view themselves more accurately, and to make connections between past and current conflicts that illuminate the way one relates to oneself and to others. I will be encouraged to talk about thoughts and feelings that arise in therapy.

I understand that while psychotherapy may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories. Psychotherapy can be relatively short-term when the focus is limited to resolve specific symptoms or problem areas, or longer term if the treatment focus targets more pervasive or long-standing difficulties. When the client feels she or he has accomplished the desired goals, then a termination date can be set. Psychotherapy aims to help people experience life more deeply, enjoy more satisfying relationships, resolve painful conflicts, and better integrate all the parts of their personalities.

I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California.

Confidentiality:

I understand that all information shared with my therapist is confidential and no information will be released without my consent. In all situations, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

1. When there is risk of imminent danger to myself or to another person, the therapist is ethically bound to take necessary steps to prevent such danger.
2. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the therapist is legally required to take steps to protect the child, and to inform the proper authorities.
3. When a valid court order is issued for medical records, the is bound by law to comply with such requests.

Availability and After-hours Contact Information:

I am aware that my therapist can be contacted during normal business hours by leaving a voice message. Should an emergency arise, I understand that I may contact my therapist and expect a reply in a timely manner unless there are extenuating circumstances.

Financial Terms:

I understand that fees have been discussed prior to initial assessment. I understand that I am responsible for payment prior to the beginning of session. I am aware that there are possible charges for written reports depending on the length of time required to complete the report.

Notice To Clients

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Termination of Treatment:

I understand that the therapist may terminate treatment if payment is not timely, if prescriptions are not filled (such as seeking consultation, refraining from dangerous practices, coming to sessions sober, etc.), or if some problem emerges that is not within the scope of competence of the therapist. The usual minimal termination for an ongoing treatment process is four to ten sessions but a satisfying termination to long-term work may take a number of months.

If I have any questions regarding this consent form or about the services offered, I may discuss them with my therapist. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me. I understand that I may stop treatment at any time.

Name _____

Signature _____

Date: _____