Dr. Beth Elder, L.C.S.W., Psy.D.
18600 Main Street, Ste. 295
Huntington Beach, CA 92648

New Patient Information

Name: ____ Today's Date: _____________________

Date of Birth: _________________ Age: ____ Sex: M ☐ F ☐ SS#:_____________________________

Address: ____

City: _______________________________________ Zip: ____

Cell Ph: ____________________ Work Ph: _____________________Home Ph: _____________________

Marital Status: __________________________ Spouse's Name: __________________________________

Children's Names and Ages: ____

Employer: ___________________________________ Occupation: _________________________________

Presenting Problem or Reason for Seeking Treatment: ____

____

Referred By: ____

Primary Care Physician: ____

Ph #: _____________________________________ Date Last Seen: _________________________________

Current Medications and for What Condition:

____

____

Current and Past Medical Conditions and/or Surgeries: ____

Emergency Contact: ____________________________ Ph #: _____________________________________

Insurance Information

Primary Insurance: ____ Policy#: ______________________

Subscriber's Name: ____________________________________ Subscriber's SS#: ____________________

Group#: ____________________________________ Ph#: ____

Authorization # for these sessions: ____

(Please be advised it is the member's responsibility to obtain authorization prior to treatment)

Assessment of Life Role Functioning

Please indicate how your emotional status or problem(s) have affected the following areas (Circle Choice).

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Marriage/Relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School Performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Hobbies	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A
Anxiety Level/Nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Eating Habits	1	2	3	4	5	N/A
Sleeping Habits	1	2	3	4	5	N/A
Sexual Functioning	1	2	3	4	5	N/A
Ability to Concentrate	1	2	3	4	5	N/A
Ability to Control Own Temper	1	2	3	4	5	N/A
Spirituality	1	2	3	4	5	N/A

Family History of any Psychological or Psychiatric Conditions:
____

History of Personal Psychological or Psychiatric Conditions

Have you or are you currently receiving psychiatric or psychological treatment of any kind? Yes ☐ No ☐

If you indicated "yes," please answer the following questions:

What type of care did you receive? Outpatient ☐ Inpatient (hospital Program) ☐ Both ☐

What dates where you in treatment: ____

Who was treating you (provider name):____

Please describe what you either liked or disliked about your treatment: _____________________________

____

Were you prescribed any medication at that time? Yes ☐ No ☐ If so, what you were prescribed: _____

____

Habits: Coffee (Cups/Day): ___________________________ Cigarettes (Packs/day): __________________

Other habits not listed: ____

Current and Past Substance Use

When was the last time you drank any alcohol? ____

Pleas list the types of alcohol you drink and the frequency with which you consume it:

Type (i.e. beer, vodka)	Frequency	Amount

When was the last time you used any recreational drug (i.e. marijuana, cocaine, speed, heroin, ecstasy, LSD, etc.)? ____

Please list the types of drug(s) you use and the frequency with which you use it:

Type	Frequency	Amount

Have you ever received any type of treatment for substance abuse? Yes ☐ No ☐

If you answered "yes," please answer the following questions:

What type of treatment did you receive? Please circle all that apply:

Inpatient (hospital program) ☐ Intensive Outpatient (IOP) ☐ Outpatient ☐ Support Groups (AA, NA) ☐

What dates where you in treatment: ____

Have you had any periods of sobriety? Yes ☐ No ☐ Dates of Sobriety: ____________________________

Legal History

Are you involved in any legal proceedings? Yes ☐ No ☐ Comments: ____________________________

____

Have you ever been arrested? Yes ☐ No ☐ Have you ever been convicted of a crime? Yes ☐ No ☐

Comments: ____

Is there anything significant the form did not ask that you would like to add? ______________________

____

____

Assignment of Benefits

I authorize release of information necessary to file a claim with my insurance company and assign benefits to be paid directly to my provider listed on the claim. I understand that I am financially responsible for all charges regardless of insurance payments.

____ _________________________________

(Signature of Insured/Patient) (Date)

Release of Information to Insurance Carrier

I hereby authorize release of information for claims processing, case management, certification, authorization, quality improvement or other purposes as required by my health plan.

____ ___________________________

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

Financial Responsibility

I understand and agree with the following:

I understand that billing my insurance company is done as a courtesy to me and that all payment is typically due at the time services are rendered.

If my insurance company fails to pay claims submitted for services rendered in this office by my provider, I understand I am financially responsible for any and all fees I incur.

I will be given the opportunity to contact my insurance company to try to resolve the reason why claims were denied.

If payment by my insurance company is not received in a reasonable period of time, the billing department will send a statement that I agree to pay in full in a timely manner.

I understand that my provider may utilize the services of a collection agency, should said payments not be made.

____ ________________________________

(Signature of Patient/Guardian) (Date)

Financial Responsibility for Account

Payment for professional services is expected at the time of each session. If you accrue an outstanding balance, the credit card on file will be charged the balance unless other financial arrangements have been made with Dr. Elder. It is important to remember that you will be charged a $60.00 fee in the event of a late cancellation (less than 24 hrs. notice, except for Monday appointments that must be cancelled by Friday), or a missed session (no show). Please indicate how you would like to receive your statements:

☐ Paper statements via U.S. Mail
☐ Electronic statement E-mail address: ____

Responsible Party Information:

☐ I am financially responsible for my account
☐ Another party is responsible for my services:
Last Name: __________________________ First Name: ___________________________ Middle Initial: _
Billing Address: ____
City: _________________________________ State: ___________________ Zip Code: _________________
Phone: _____________________________

Credit Card Authorization

It is your responsibility to provide complete and accurate information for billing and/or filing insurance claims. Additionally, it is your responsibility to provide Dr. Elder with any changes of information such as insurance coverage or policy changes, including if your credit card is expired or declined and needs updating, as soon as possible. If another individual is financially responsible for your services, the authorized representative named in the section above must complete and sign this credit card authorization. Should another party be responsible for your services, you (the client) should not complete the credit card information section on their behalf.

I, _______________________________, authorize Dr. Elder to charge the balance due on this account to the credit card indicated below.

Card Type: Visa ☐ Master Card ☐ American Express ☐ Discover ☐
Credit Card #: ____ CVC #: _____________
Exp Date: ____________________ Name on Card: _________________________________
Billing Address and Zip Code: ____

I have read the above information regarding my Fee Arrangement carefully, and I understand and agree to comply with all its terms and conditions:
Authorized Cardholder's Signature: ____

Late Cancellation and Missed Appointment Policies

Please be advised of the following cancellation policy:

1. All appointments must be cancelled no less than 24 hours prior to your scheduled appointment time. There will be no exceptions.
2. There will be a $60.00 charge for all late cancellations and missed appointments. Since we are unable to bill your health insurance, you will be held responsible for this charge.
3. Should your scheduled appointment fall on a Monday, you must cancel by 2 p.m. the Friday directly preceding.
4. Illnesses or child care issues are not considered acceptable forms of exceptions for late cancellations or missed appointments. Please plan accordingly. If you feel an illness approaching, you must adhere to the cancellation policy.
5. The will be no charge for arriving late to your appointment as long as you arrive within 30 minutes of your scheduled time. Please keep in mind that the total allotted appointment length time is 50 minutes.
6. All cancellations must be communicated directly to your therapist preferably by calling the cell phone at 949-743-1775 and leaving a message. Please refrain from sending text messages or emails as means of cancellation. THIS PHONE NUMBER DOES NOT RECEIVE TEXTS.

I have read and agree with all of the terms of the Late Cancellation and Missed Appointment Policies.

________________________________ _______________

Signature of Patient/Guardian Date

HEALTH INFORMATION PRIVACY ACT ADMINISTRATION NOTICE OF PRIVACY PRACTICES

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.

It Is Your Therapist's Legal Duty To Safeguard Your Protected Health Information (PHI).

By law your therapist is required to ensure that your PHI is kept private. The PHI constitutes information created or noted by your therapist that can be used to identify you. It contains data about your past, present, or future health/mental health or condition, the provision of health care services to you, or the payment for such health care. Your therapist is required to provide you with this Notice of Privacy Practices about their privacy procedures. This Notice must explain when, why, and how your therapist would use and/or disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. Use of PHI means when your therapist shares, applies, utilizes, examines, or analyzes information within the practice; PHI is disclosed when your therapist releases, transfers, gives, or otherwise reveals it to a third party outside the practice. With some exceptions, your therapist may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, your therapist is always legally required to follow California law and the privacy practices described in this Notice.

Please note that your therapist reserves the right to change the terms of this Notice and the Privacy Policies at any time. Any changes will apply to PHI already on file with your therapist. Before your therapist makes any important changes to the policies, they will immediately change this Notice and post a new copy of it in the office or on their website, or provide the updated document to you at your next appointment. You may also request a copy of this Notice from your therapist.

How Your Therapist Will Use And Disclose Your PHI.

Your therapist will use and disclose your PHI for many different reasons. Most of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of your therapist's uses and disclosures, with some examples.

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. Your therapist may disclose PHI to any other consultant with your authorization.

For Payment. Your therapist may use and disclose PHI so that they can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use a collection processes due to lack of payment for services, your therapist will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. Your therapist may use or disclose as needed PHI in order to support their business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, your therapist may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided they have a written contract with the business that requires them to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, your therapist must disclose your PHI to you upon your request. In addition, your therapist must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining his or her compliance with the requirements of the Privacy Rule.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is my practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Uses and Disclosures Related to Treatment, Payment, or Health Care Operations That **Do Not** Require Your Prior Written Consent:

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement.** Your therapist may make a disclosure to the appropriate officials when the law requires them to report information to courts, government agencies, law enforcement personnel, and/or in an administrative proceeding. This includes search warrants and court orders for release of records. If you, or anyone else, places your mental condition as a part of any litigation (such as divorce, custody, or personal injury), your therapist may be compelled to release your PHI.
2. **Disclosure is compelled or permitted when you are in such mental or emotional condition as to be dangerous to yourself and if your therapist determines that disclosure is necessary to prevent potential harm.** For example, suicidal or serious self-destructive behavior.
3. **Disclosure is mandated by the California Child Abuse and Neglect Reporting law.** For example, if your therapist has a reasonable suspicion of child abuse or neglect.
4. **Disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law.** For example, if your therapist has a reasonable suspicion of elder abuse or dependent adult abuse.
5. **Disclosure is mandated when you tell your therapist of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.** Also, confidentiality does not apply to disclosure of crimes planned for the future. This applies to interests of national security, such as protecting the President of the United States or assisting with intelligence operations to prevent future terror activities.
6. **When disclosure is required to obtain payment for treatment.** Your therapist might send your PHI to your insurance company, health plan, or other third party payer in order to receive payment for services your therapist provided to you. Your therapist may also provide your PHI to business associates, such as billing companies or others that process health care claims for the office.
7. **Appointment reminders and health related benefits or services.** Your therapist may use PHI to provide appointment reminders. Your therapist may use PHI to give you information about alternative treatment options, or other health care services or benefits your therapist offers.
8. **When disclosure is otherwise specifically required by law.** Your therapist may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime of the premises.
9. **When disclosure is required by specialized government functions.** Your therapist may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
10. **When disclosure is required for medical emergencies.** Your therapist may disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Your therapist will try to provide to you a copy of this notice as soon a reasonably practicable after the resolution of the emergency.
11. **When disclosure is required for public health purposes.** If required, your therapist may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
12. **When disclosure is required to ensure public safety.** Your therapist may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
13. **When disclosure is required for research purposes.** PHI may only be disclosed after a special approval process or with your authorization.
14. **When disclosure is done with verbal permission.** Your therapist may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

15. When disclosure is required regarding deceased patients. Your therapist may disclose PHI regarding deceased patients as mandated by state law or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as the next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.
16. When disclosure is otherwise necessary for health oversight. If required, your therapist may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.

Other Uses and Disclosures Require Your Prior Written Authorization. For situations not described above, your therapist will require written authorization before disclosing any of your PHI. This includes communication with family members or other health care providers. Even if you signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future disclosures.

What Rights You Have Regarding Your PHI:

You have the following rights regarding PHI that is maintained about you. To exercise any of these rights, please submit your request in writing directly to your therapist, as he or she is your Privacy Officer.

- **Right of Access to Inspect and Get Copies of Your PHI.** In general, you have the right to see your PHI that is in your therapist's possession, or to get copies of it; however, you must request it in writing. You will receive a response from your therapist within 5 days of receiving your written request. Under certain circumstances, your therapist may deny your request. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. If they do, your therapist will give you, in writing, the reasons for the denial. You have the right to have the denial reviewed. If you ask for copies of your PHI your therapist may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person. Your therapist may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.
- **Right to Amend**. If you feel that the PHI your therapist has about you is incorrect or incomplete, you may ask to amend the information although your therapist is not required to agree to the amendment. If your therapist denies your request for amendment, you have the right to file a statement of disagreement with your therapist. Your therapist may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to Request Restrictions**. You have the right to ask that your therapist limit how he or she uses and discloses your PHI, specifically regarding treatment, payment, or health care operations. You do not have the right to limit the uses and disclosures that they are legally required or permitted to make. Your therapist is not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, your therapist is required to honor your request for a restriction.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain disclosures that your therapist makes of your PHI. Your therapist may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Confidential Communication**. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by postal mail). Your therapist will accommodate reasonable requests. Your therapist may require information regarding how payment will be handled or specification of an alternative address or other method

of contact as a condition for accommodating your request. Your therapist will not ask you for an explanation of why you are making the request.

- **Breach Notification**. If there is a breach of unsecured PHI concerning you, your therapist may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice**. You have the right to a copy of this notice.

I acknowledge the terms of this notice and the privacy practices of this office.

____ Relationship to patient: ______

Signature Name (print) Date

____ Relationship to patient: ______

Signature Name (print) Date

INFORMED CONSENT FOR PSYCHOTHERAPY SERVICES & OFFICE POLICIES

This form provides you (patient) with information that is additional to that detailed in the Notice of Privacy Practices. Please initial each paragraph in the space provided indicating that you have read and understood the content of that paragraph.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (patient's) written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure were described to you in the Notice of Privacy Practices that you received with this form.

Initial ______

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 patient presents a danger to self, to others, or is gravely disabled (see also Notice of Privacy Practices form).

Initial ______

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 your therapist. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Your therapist will not release records to any outside party unless they are authorized to do so by **all** adult family members who were part of the treatment.

Initial ______

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 highly sensitive and of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you, nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify at any proceeding, nor will a disclosure of the psychotherapy records be requested. By signing your name to this informed consent contract, you agree that if your therapist, Beth Elder, L.C.S.W., Psy.D., is brought into a legal matter involving you, in any way, you will compensate your therapist at the rate of $250.00 per hour. You agree that these fees are higher rates than the normal hourly fees for psychotherapy, and that is because your therapist's involvement is energy/time-consuming that interferes with the normal routine of running the practice.

Initial ______

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier, HMO/PPO/MCO/EAP, or other third party payer in order to process the claims. Only the minimum necessary information will be communicated to the carrier. Unless authorized by you explicitly, the psychotherapy notes will not be disclosed to your insurance carrier. Your therapist has no control or knowledge over what insurance companies do with the information they submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information, including diagnosis, is entered into insurance companies' computers and will also be reported to the

congress-approved National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has been reported to have been sold, stolen, or accessed by enforcement agencies; therefore, you are in a vulnerable position.

Initial ______

Confidentiality of E-mail, Cell Phone and Faxes Communication: It is very important to be aware that e-mail, texts, and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be 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 easily be sent erroneously to the wrong address. Please notify your therapist at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mail, texts, or faxes for emergencies.

Initial ______

Consultation: Your therapist may consult with other professionals regarding their patients; however, the patient's name or other identifying information is never mentioned. The patient's identity remains completely anonymous and confidentiality is fully maintained. This is done to provide you with the best care possible.

Initial ______

The Process of Therapy: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Psychotherapy requires your very active involvement, honesty, and openness in order to change. Your therapist will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. During therapy, remembering or talking about painful memories, unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings. This may include anger, sadness, worry, fear, shame, anxiety, depression, insomnia, etc. Your therapist may challenge some of your assumptions and/or perceptions and propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing perceptions, beliefs, behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, your therapist is likely to draw on various psychological approaches according, in part, to the problem that is being treated and their assessment of what will best benefit you. Sometimes more than one approach can be helpful in dealing with a certain situation. These approaches may include, but are not limited to: cognitive-behavioral, psychodynamic, EMDR, behavioral, existential, systems/family of origin, developmental (adult, child, family), biblio-therapy, or psycho-educational.

Initial ______

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment, your therapist will discuss with you their working understanding of the problem, treatment plan, therapeutic objectives, and view of the possible outcomes of treatment. If you have any unanswered questions about the course of your therapy, the possible risks, your therapist's ability, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other

treatments for your condition and their risks and benefits. If you could benefit from any treatment that your therapist does not provide, they have an ethical obligation to assist you in obtaining those treatments.

Initial ______

Termination: You have the right to terminate therapy at any time. Ideally, this happens when the goals of therapy have been met. If at any point during psychotherapy your therapist believes they are not effective in helping you reach the therapeutic goals, they are obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, they would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, your therapist will talk to the new psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, your therapist will assist you in finding someone qualified, and with your written consent will provide her or him with the essential information needed.

Initial ______

Dual Relationships: A dual relationship exists when you have some type of relationship with your therapist outside the clinical setting. This may include civic and philanthropic groups, religious communities, sports leagues, etc. For the best possible outcome and care of your treatment, you and your therapist will refrain from engaging in any type of dual relationship. Therapy NEVER involves sexual or any other dual relationship that can be exploitative in nature, or impairs your therapist's objectivity, clinical judgment and/or therapeutic effectiveness.

Initial ______

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact your therapist between sessions, please leave a message on your therapist's voice mail and your call will be returned as soon as possible. All urgent calls will be returned within 24 hours. Understand that your therapist may charge you for services rendered over the phone. Please clarify with your therapist about their policy in this regard. If an emergency situation arises, please indicate it clearly in your message. *In case of an emergency, or when there is immediate danger or potential for harm, call 911.*

Initial ______

PAYMENTS & INSURANCE REIMBURSEMENT: Patients are expected to pay the standard fee of $175.00 per 45-50 minute session at the end of each session unless other arrangements have been made. Telephone conversations, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, etc. will be charged at the same rate, unless indicated and agreed otherwise. Please notify your therapist if any problem arises during the course of therapy regarding your ability to make timely payments. Health insurance is a contract between you and your insurance company. Patients who carry insurance should remember that professional services are rendered and charged to the patient and not *to* the insurance company. As was indicated in the section *Health Insurance & Confidentiality of Records,* be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems which are the focus of psychotherapy are reimbursed by insurance companies; it is your responsibility to *verify* the specifics of your coverage.

Initial ______

I have read the above Informed Consent for Psychotherapy Services & Office Policies carefully; I understand them and agree to comply with them.

____ ___________________________
(Signature of Patient/Guardian) (Date)

____ ___________________________
(Signature of Patient/Guardian) (Date)

Please complete this area if you are uninsured or choosing to *not* to use your insurance.

Alternative Fee Agreement: I agree to pay $______ per session, to be paid:
□ at time of service □ when billed.

Therapist approval of Alternative Fee Agreement: ____________________________

____ __________________________
(Signature of Patient/Guardian) (Date)