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Marriage and Family Therapist
California License # MFC30378

INFORMED CONSENT FOR PSYCHOTHERAPY CONSULTATION

The state expects that you will be informed of all possible contingencies that might arise in the course of your short-and long-term psychotherapy. Please check to be sure you have read, understood, and discussed all questions with Dr. Healey. An informed consent has the force of contract, so we cannot proceed until we reach an agreement on all items.

Background Information

Name _____ M/F

Home Address _____

City _____ Zip Code _____

Home Phone () _____ OK to contact Y/N

Work Phone () _____ OK to contact Y/N

Cell Phone () _____ OK to contact Y/N

Email address _____ OK to contact Y/N

Mailing Address (If different) _____

Business Address _____

Date of Birth _____ Social Security # _____

Driver's License # _____ Physician's Name _____

Physician's number () _____ Date of Last Physical _____

Referred By _____

Person and No. to call in emergency _____

The Therapy Process (Initial indicates that you read and understood this section _____)

The type of treatment will be (circle all appropriate)

1. Individual 2. Couple 3. Other (_____)

Reasons why I am seeking psychotherapy treatment at this time:

- _____
- _____
- _____
- _____
- _____

Psychotherapy Arrangements (Initial indicates that you read & understood this section _____)

I agree to the treatment developed by my therapist and myself. The initial plan is for sessions to be weekly. Certain situations may necessitate more or less than one session per week and my therapist will give recommendations for frequency depending on how I am progressing.

There may be times when my therapist will recommend that I contact a physician, psychiatrist, or other professional to seek services that could aid in my treatment. I agree to follow through with such recommendations and am aware that my therapist may choose to discontinue therapy with me should I not comply with recommendations that are deemed critical to my treatment.

I will bring other persons to scheduled sessions only by prior agreement with my therapist.

I agree to be present for the full length of therapy sessions (50 minutes, unless modified previously by both therapist and myself).

Appointment Cancellations (Initial indicates that you read & understood this section _____)

Due to the nature of the practice, you will be held responsible for all *scheduled* consultation sessions **whether or not you are able to attend.**

Neither the therapist nor I will cancel an appointment with **less** than 24 hours notice, except in a rare emergency. If the therapist cancels in less than 24 hours without an emergency, I will have a session without charge. In the event that I cancel, in less than 24 hours notice without emergency, I will pay the usual full fee. (Monday appointments must be cancelled by noon on the proceeding Friday.)

Telephone

The usual method of communication between sessions will be by telephone. Changes to the agreed upon schedule will be made either in person or via telephone, with the initial message returned for confirmation.

Calls for purposes other than information or scheduling will be charged in quarter-hour increments of the full fee (e.g., 15 minutes = 25% of full fee).

The therapist is often not immediately available by telephone but has voice mail that is monitored frequently. The therapist will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform the therapist of some times when you will be available. **If you are unable to reach the therapist and feel that you can't wait for them to return your call, contact your family physician or the nearest emergency room and ask for the psychologist on call.** If the therapist will be unavailable for an extended time, they will provide you with the name of a colleague to contact, if necessary.

Email

Unless otherwise agreed to by my therapist, email may only be used by my therapist and authorized staff to aid in the scheduling of appointments (session cancellations must be made by phone), and to send necessary forms to me.

Limits of confidentiality (Initial indicates that you read & understood this section _____)

State law and professional ethics require therapist to maintain confidentiality except for the following situations:

1. If there is suspected child abuse, elder abuse, or dependent adult abuse.
2. "Tarasoff" situations in which serious threat to reasonable well identified victim is communicated to the psychotherapist by the client or when the client's family member/s communicate to the therapist that the client presents a danger to others.
3. When threat to injure or kill oneself is communicated to the psychotherapist.
4. If you are required to sign a release of confidential information by your medical insurance.
5. If you are required to sign a release for psychotherapy records if you are involved in litigation or other matters with private or public agencies. *(Think carefully and consult with attorney before you sign away your rights. We can discuss some foreseeable possibilities together if appropriate).*
6. Clients being seen in couple, family, and group work are obligated legally to respect the confidentiality of others. The psychotherapist will exercise discretion (but cannot promise absolute confidentiality) when disclosing private information to other participants in your treatment process. Secrets cannot be kept from the psychotherapist from others involved in your treatment process.
7. I may at times speak with professional colleagues about our work without asking your permission, but your identity will be disguised.
8. My support staff has access to locked records, but is legally charged with confidentiality.
9. Clients under the age of eighteen (18) do not have full confidentiality from their parents.

Other potential limits to confidentiality may be the following:

1. All records spoken as well as written notes on sessions, e-mails, and phone calls can be subject to court subpoena under certain extreme circumstances. Most records are stored in locked files but some are stored in secured electronic devices.
2. Cell phones, portable phones, faxes, and e-mails are used on some occasions.
3. All electronic communication such as e-mails could compromise your confidentiality.

Fees (Initial indicates that you read & understood this section _____)

- My fee is \$150.00 per 50 minute session, \$225.00 per 75 minute session.
- You are expected to pay the agreed fee of _____ per _____ minute session. *Session fee will be reviewed upon _____, at which time any necessary fee adjustments will be made in agreement between therapist and client.*
- Fee is payable at the beginning of each session, unless other arrangements are made.
- Fee will be agreed upon in the first treatment session.
- If fee is not paid at the time of each session, I will be billed at the end of the month, and full payment is required by the 10th of the next month.

- Payment shall be made directly to Dr. Patrick Healey, who will assist in obtaining reimbursement if requested.

Payment for returned checks and penalty fees are due upon notification. The therapist has the right, after fees are three months overdue and I have been notified of the same, to engage the services of a collection agency. If payment becomes a problem for me, I will discuss this directly with the therapist. If the therapist's fees change during the course of treatment, I will have three months notice of same. Telephone calls may be charged at approximately the same rate as personal consulting plus any telephone company charges. All services rendered on holidays, and between 9:00pm through 8:00 am are subject to one and one-half of the hourly rate.

Interest at 12% percent per annum will be charged on all accounts over 60 days due.

Release of Information (Initial indicates you have read & understood this section _____)

I authorize release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purposes of diagnosis, treatment, consultation, and professional communication. If I am an insured client, I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration, and other purposes related to my health plan.

Psychotherapist's Availability (Initial indicates you have read & understood this section _____)

The therapist is available for regularly scheduled appointment times. Dates of vacations and other expectations will be discussed in advance as much as possible.

Telephone appointment times can be made by previous arrangements.

Emergency Service

Any emergency service will be established between me and the therapist on an individual basis and particular circumstance. I may be charged for telephone consultation in excess of 10-15 minutes.

Termination of Treatment (Initial indicates you have read & understood this section _____)

The therapist may terminate treatment for the following reason:

- If payment is not timely
- If client is not compliant with recommended treatment (such as seeking consultation, refraining from dangerous practices, coming to sessions drunk, etc),
- If client drops out of treatment against the therapist's advice for over three months, and
- If some problem emerges that is not within the therapist's scope of competence

The usual minimal termination for an ongoing treatment process may require three, four or more sessions, but a satisfying termination to long-term work may require a number of months. Should I decide to terminate therapy, I agree to first schedule a final session with my therapist.

Clients have the right to refuse or discontinue services at any time.

General Comments (initial indicates you have read & understood this section ___)

I understand need to consider all of the following

- The risks and benefits that major psychological transformation may have on current relationship(s)
- The possible need of psychiatric consultation during periods of extreme depression or agitation.
- That not all people experience improvement from psychotherapy, and
- That psychotherapy may be emotionally painful at times.

Agreement for Psychotherapy Consultation (Initial indicates you have read & understood this section _____)

I have read this informed consent completely and have raised any questions I might have about it with the therapist. I have received full and satisfactory response and agree to the provisions freely and without reservations.

I am entering into this psychotherapy consultation contract with full understanding, participation, and consent. I authorize and request the therapist to carry out psychological and psychotherapeutic exams, treatment, and/or diagnostic procedures which now, or during the course of my treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement.

I understand that while the course of my treatment is designed to be helpful, my therapist can make no guarantees about the outcome of my treatment. Furthermore, I understand that the psychotherapy process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between the therapist and myself during our visits.

I understand that my therapist is responsible for maintaining all professional standards set forth in the ethical principles of professional association as well as the laws of the state of California governing the practice of psychotherapy and he/she is liable for infraction of those standards.

I understand that I will be fully responsible for any and all legal and/or collection costs arising as a result of my breach of this contract with my therapist, including appropriate compensation for his/her time involved in preparing for and doing court work.

I understand that my therapist, from time to time, makes teaching and research contributions using disguised client material. By consenting to treatment I am giving consent to this process of professional contribution and the right to use disguised material without financial remuneration.

Arbitration Agreement (Initial indicates you have read & understood this section _____)

I agree to address any grievances I may have directly with my therapist immediately. If we cannot settle the matter between us, then a jointly agreed upon outside consultation will be sought. If not, an arbitration process will be initiated, which will be considered as a complete resolution and legally binding decision under state law, which in California states as follows:

