DEBORAH LEEDS, MFT
925.685.9463 ext.2
MFC#29407

INFORMED CONSENT

The purpose of this form is to advise you of important information for you to know prior to beginning psychotherapy sessions with me.

1.) Confidentiality: Everything which takes place in the course of our therapy sessions is confidential. I cannot release any information to anyone without your written consent. If you are involved in couple's therapy, both partners must sign off before I can release any information.

There are, however, these exceptions:

A. Insurance: If you are seeing me through your insurance company, I will be required to provide them with basic information regarding your treatment, such as symptoms, diagnosis, prognosis, and dates of service.

B. Legal Mandates for Breaking Confidentiality: In certain circumstances, I am required by law to break your confidentiality when there is reasonable suspicion of child abuse (a minor under 18 years of age), elder abuse (someone over the age of 65), or if you pose an imminent risk of serious physical harm to yourself or another person.

C. Consultation: There are times I find it necessary and ethical to seek outside consultation with another licensed professional. In these instances, I use no identifying information verbally, nor do I provide any written documentation.

D. Collections: If the situation arises wherein there is a failure to make payments, I may release your name and the amount owed to a collection agency. You will be advised of this before this step is taken.

2.) Record Keeping: Like all professionals, I maintain a case file on your treatment which includes basic identifying information, a record of all financial transactions, and progress notes. These are kept in a locked file during your treatment, and in a secure facility for seven years following the termination of your treatment.

3.) Qualifications: I am a licensed Psychotherapist, a Certified Imago Therapist, a certified Encounter-centered Couples Therapist, and am a certified EMDR practitioner.

4.) Treatment Length: The time you spend in psychotherapy or couples therapy is affected by a number of elements, including your symptoms, your goals, your resources, and the benefits of our working relationship. As we work together on your goals, it is possible that you may experience increased distress as you allow yourself to feel pain that is present for you, or memories that are difficult but significant to explore in working to relieve you of that for which you are seeking therapy. There is the possibility that treatment may not be effective. I will check in with you, and you may always bring up with me the question as to your progress and/or the effectiveness of our work together. You have the right to terminate at any time.

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5.) Fees: My fees for private pay clients are $150.00 per hour. Sessions are 50 minutes. Fees for couples sessions vary depending on the format we determine together. All fees, including copays, are due at the time of our session. Clients are responsible to provide their insurance with the necessary information to ensure timely authorization and payment. You are ultimately responsible for your bill, and if your insurance company does not pay, you will be expected to cover the fees for your sessions. Cash or checks are acceptable. If you wish to write a check, please make it payable to me and have it prepared before we begin our session, so that we do not need to end early to allow you the time to write it.

6.) Cancellation/Reschedule Policy: I require 48 hours notification for a schedule change or cancellation. You are responsible for the full fee of the session if notification is less than 48 hours. When that situation arises, I try my best to reschedule you during the week, or to fill your time with another client, in which case you will not be charged. This rule applies for all circumstances, including illness, except for hospitalization. Although I regret having to enforce this policy, it is a standard in this field given the intersection of the provision of our services with the necessities of business.

7.) Emergency Access: I will provide you with the name and contact information for the practitioner who covers my practice when I am away and cannot be reached. Otherwise, you may leave me a message at anytime, or, if you are in immediate crisis, go to your nearest hospital.

I understand and agree to these terms and conditions.

_____ _____

(Client) (Client)

_____

(Date)