4419 Van Nuys Blvd. #206 Sherman Oaks, CA 91403
818-351-3511

CONSENT FOR TREATMENT

I, _____, authorize and request that_____ _____., carry out psychological treatment, examinations, and/or diagnostic procedures, which now, or during the course of my care as a patient, are advisable. I understand that the purpose of these procedures will be explained to me, and will be subject to my agreement. I understand that_____ _____. is a licensed therapist/psychologist, and her license number is ____ _____.

OFFICE POLICY

Confidentiality: All information disclosed within sessions is confidential and may not be revealed to anyone without written permission, except where disclosure is required by law. Disclosure may be required in the following circumstances: where there is a reasonable suspicion of child abuse, incest or elder adult abuse; where there is a reasonable suspicion that the patient presents a danger of violence to others or where the patient is likely to harm him or herself, unless protective measures are taken. Disclosure may also be required pursuant to legal proceeding.

Insurance: I am not a contracted provider but will provide superbills for Insurance purposes. Insurance companies may require disclosure of information in order to process claims. **You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. By signing this agreement, you agree that I can provide requested information to your carrier.**

Electronics: Use of text services, emails, cell phones, Skype, facetime cannot guarantee confidentiality and use of such services confirms understanding of this lack of guarantee of confidentiality with use of text, cell, email, and Skype or facetime.

TRAUMA&BEYOND
PSYCHOLOCICAL CENTER

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Payment For Services: Patients are expected to pay for services at the time they are rendered unless other arrangements have been made. Patients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. I will provide you with a statement, which you can submit to your insurance company for reimbursement or I may be able to submit for you. In instances, where extraordinary professional time is required, you may incur additional fees.

Cancellations: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for rescheduling or cancellation of an appointment. The full fee will be charged for missed sessions without 24 hour notification.

Availability: I will make every effort to return calls within 24 hours (or by the next business day) but cannot guarantee the calls will be returned immediately. I am unable to provide 24-hour crisis service. In the event that a client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

THE THERAPY PROCESS

Participating in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working towards these benefits, however, requires effort on your part and may result in your experiencing some discomfort.

Remembering and resolving unpleasant events through therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family
members, and other individuals, can also lead to discomfort and may result in changes that were not originally intended.

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Signatures Verifying Agreement: Your signature below indicates that you have read the information in this document that you have understood it, and that you agree to abide by its terms as long as you are receiving services from me.

_____ _____ _____
Client Name Printed Date Client Signature

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____

Phone Cell: _____

Phone Home: _____

Email: _____

Insured's Date of Birth: _____