# CONSENT FOR TREATMENT

I (Name)_____
give my permission to Elizabeth Davis, LMFT, BCBA (a Licensed Marriage and Family Therapist and Board Certified Behavior Analyst) to provide counseling and psychotherapy to me and agree to fully participate in therapy through the process of assessment, treatment planning and termination. I understand that client's input is important in establishing the frequency and duration of counseling.

I agree to disclose any pertinent mental health history and medical information that will assist in my treatment.

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 of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to: divorce, custody disputes, injuries, lawsuits, etc.) **neither you, as the client(s), nor your attorney, nor anyone else acting on your behalf, will call upon your therapist to testify in court or in any other legal proceedings or legal capacity, nor will a disclosure of psychotherapy be requested.**

I understand that all communication between me and the therapist is both privileged and confidential. All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in couples or family therapy your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. In additions, your therapist will not disclose information communicated privately to her by one family member to any other family member without written permission.

**Information may be released under the following exceptions to confidentiality:**

- California law has held that if the therapist believes that an individual intends to do physical harm to another, it is the therapist's duty by law to take protective action, which may include notifying the potential victim and/or the family of the person who is likely to suffer the results of harmful behavior, notifying the police, or another appropriate person. Therapist may also be required or permitted to break confidentiality when they have determined that a client is dangerous to him or herself or who may have suicidal intentions.

- California law also mandated that therapists report any suspected child abuse, suspected elder abuse or suspected abuse of a disabled / dependent person.

- Release of limited information required by your insurance agency.

- If you introduce your emotional condition into a legal proceeding.

**Fees and Insurance:**

The fee for service will be $_____ per 50 min session and $_____ per 80 min session and $_____ per 110 minute session.

Fees are due and payable at the time of each visit unless other arrangements have been made.

Please inform your therapist if you wish to utilize health insurance to pay for services. If Elizabeth is a contracted provider for your insurance company, Elizabeth will discuss the procedures for billing you insurance. The amount of reimbursement and the amount of any co-payments or deductible depends o the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although Elizabeth is happy to assist your efforts to seek insurance reimbursement, she is unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with your therapist.

If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Elizabeth will help you to consider any options that may be available to you at that time.

☐ Therapist is an Insurance Network Provider

☐ Other:_____

**Appointment Scheduling and Cancellation Policies:**

- Appointments are generally made on a regular, weekly basis and your session is held for you from week to week. In a sense, you have a contract whereby you have the exclusive use of a therapist's time for your scheduled appointment.
- You are therefore held responsible for the fee for the appointment. Please understand that your insurance company will not pay for missed or cancelled sessions. In the event that you are unable to keep your appointment, you must cancel as soon as possible. If this is done at least 24 hours in advance of your appointment time, there will be no charge for the cancellation.
- **If you do not provide your therapist with at least 24 hours notice in advance, you are responsible for payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions.**
- The same policy applies to any group counseling or therapy session you may be participating in.
- **You understand that you are completely responsible for the payment of the services provided by Elizabeth Davis, LMFT, BCBA in the event that your Insurance company, EAP services, any other entity does not pay or reimburse for the services provided.** _____
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- I have a policy known as **Fee For Service**. I ask that you pay at each session. This includes any co-payments that may apply. Please feel free to discuss my fees with me. If you need to make special arrangements for payment, I will be glad to discuss special arrangements for you.
- If you request, I will be glad to provide you with a statement for your insurance company. Please remember that you are liable for my fees.
- There is a **$50.00** service charge for all returned checks.

**Therapist Availability / Emergencies:**

- You are welcome to phone your therapist in between sessions. However, as a general rule, it is my belief that important issues are better addressed within regularly scheduled sessions.
- You may leave a message for your therapist at any time on her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number along with a brief message concerning the nature of your call. Non urgent phone calls are returned during the therapist's normal workdays within 24-48 hours.
- If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provide by your therapist's voicemail.

**In the event of a medical or psychiatric emergency or any emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.**

- **Please be aware that your therapist is NOT available 24 hours a day nor on weekends and holidays.**

**Therapist Communications:**

Your therapist may need to communicate with you by telephone or other means. Please indicate your preferences by checking the applicable choices below. Please inform your therapist if you do not which to be contacted at a particular time or place or by a particular means of communication.

- ☐ My home phone number:_____.
- ☐ My cell phone number:_____.
- ☐ May send a text to my cell phone.
- ☐ May call me at work number:_____.
- ☐ My therapist may communicate with me by e-mail. My email address is:_____.
- ☐ My therapist may send mail to me at my home address.

Potential risks of using electronic communication may include, but are not limited to: inadvertent sending of an email or text containing confidential information to the wrong recipient, theft or loss of the computer, laptop or mobile device storing confidential information, and the interception by an unauthorized third party through an unsecured network. Email messages may contain viruses or other defects and it is your responsibility to ensure that it is virus-free. In addition, email or text communication may become part of the clinical record. You may be charged for time the therapist spends reading and responding to email or text messages.

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**About the Therapy Process:**

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Your therapist will work with you to develop an effective treatment plan. Over the course of therapy, your therapist will attempt to evaluate whether the therapy provided is beneficial to you. Your feedback and input is an important part of this process. It is the goal of your therapist to assist you in effectively addressing your problems and concerns. However, due to the varying nature and severity of problems and the individuality of each client, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

**Termination of Therapy:**

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan or terminating your therapy.

**Your signature indicates that you have read this agreement for services carefully and understand its contents.**

**Please ask your therapist to address any questions or concerns that you have about this information before you sign.**

Name of Client _____

Client Signature _____Date: _____