Anna Hamrell LCSW INC

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**Informed Consent for Therapy Services**

**CLIENT SERVICE AGREEMENT**

**Welcome to my practice. This document contains important information about my professional services and business policies. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.**

**PSYCHOLOGICAL SERVICES**

**Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.**

**THE PROCESS OF THERAPY**

**The therapy process can be very helpful in promoting and enhancing emotional well-being, such as improving interpersonal relationships and resolving issues and concerns that led you to seek therapy. Motivation is a key factor that predicts improvement; therefore, it requires your active involvement and openness in order to create change. The therapy process involves various stages, including assessment and exploration, goal setting, working stage, and termination. Each of the stages may need to be revised from time to time as the process and issues unfold. While the benefits of therapy are tremendous, there are some risks that can cause pain or discomfort despite its benefit. Psychotherapy may result in behavior and lifestyle changes that have the possibility of being seen as negative by someone you closely relate to. There is no guarantee that psychotherapy will yield positive or intended results.**

**Within a reasonable period of time after the initiation of treatment, I will be able to discuss with you my understanding of what our work might involve. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.**

**APPOINTMENTS
Appointments will ordinarily be 50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect the full amount.**

**PROFESSIONAL FEES
The standard fee for each session is $175.00.  You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check, credit card or cash. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.**

**In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.**

**PROFESSIONAL RECORDS
I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers.  For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional , which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.**

**CONFIDENTIALITY**

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

**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

**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.

**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.

**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. 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 a 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.

**Confidentiality of E-mail, Cell Phone and Faxes Communication:** It is very important to be aware that e-mail 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 or faxes for emergencies.

**OTHER RIGHTS
If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.**

**CONSENT TO PSYCHOTHERAPY
Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.**

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Signature of Patient or Personal Representative**

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Printed Name of Patient or Personal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Description of Personal Representative’s Authority:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**