Talyn Olguin

Licensed Marriage and Family Therapist, #89422

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818-835-2087

**AGREEMENT AND CONSENT FOR TREATMENT**

A primary reason for attending therapy is to address the problem or problems that present difficulty, uncertainty, or interfere with the more positive and productive aspects of life. A major goal in therapy is to identify those obstacles, examine the emotional patters that affect thinking and feelings which in turn impact how we function. We want to explore those origins and identify ways to move forward from unhelpful interactions. By making ourselves aware, we create the ability to understand our motivations, ways of relating and feelings which help is make new choices. With this in mind it is important to begin therapy with a clear understanding of each of our rights and responsibilities, my office policies, fee’s etc…

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do I have permission to leave a message at this number? Y/N

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do I have permission to leave a message at this number? Y/N

If not home may I contact you in case of an emergency or change of appointments?

Please leave a number if different than those listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENTS RIGHTS AND RESPONSIBILITIES**

**Confidentiality:** Trust and openness are essential for effective therapy, and I treat what you tell me with great care. My professional ethics and laws of this state prevent me from telling anyone else what you tell me unless you provide written permission. However, there are times when the law limits confidentiality and requires me to contact others. Situations when I am required to disclose information include:

1. Instances of actual or suspected physical or sexual abuse, emotional cruelty, or neglect of a child or an elder or dependent adult must be reported to the appropriate protective services
2. If I have a reason to believe that a client poses an unavoidable and imminent danger of violence to another person. I must want whoever may be in danger, and must notify the appropriate authorities.
3. If a court ordered your treatment with me, or if I am served with a subpoena. For example, in the context of a legal proceeding in which you raise your own psychological state as an issues, I am required to release information to the court, or may have to appear in court.
4. Finally, if you as a client reveal a serious intent to harm yourself, I am ethically bound to do what I can to help you keep safe, which may involve notifying others who may be of help.
5. In all of the above cases, it is incumbent upon me to release only that information necessary to appropriately carry out my responsibilities - your confidentially still remain an ethical priority.

Client initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

There are situations in which limits of confidentiality are not mandated by legal sources, and include the following.

1. Clients being seen in couple, family and group therapy are obligated to respect the confidentiality of others. I will exercise discretion when disclosing private information to other participants in your treatment process (such as your spouse, other group members, etc.).
2. I may at times speak with professional colleagues about your case without asking permission, but your identity will be disguised.
3. Client’s, under age 18 do not have full confidentiality from their parents.

Client initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note on Payment:** You will be expected to pay for each session at the time it is held unless we agree otherwise. I accept cash, check or credit card payment. I am not affiliated with any insurance or managed care companies. A fee will be charged for all returned checks.

Client initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fees:** The fee for service covers a 50 minute therapy session, including time for scheduling, payment and therapy. Per session fee will be agreed upon before the first treatment session. Telephone sessions are charged at the same rate as personal consultation and therapy. If you request it, I will give you a monthly statement, which you can use to bill your insurance for reimbursement.

Past Due Payments—Payment for services which is past due over 120 days may be subject to collection through the use of a college agency. However, efforts will be made to make other arrangements with you as needed.

Client initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note on Cancellations:** Scheduled appointment times are reserved especially for you. If you are unable to keep your appointment, please contact, via office phone r email, as soon as possible. Sessions canceled within less than a 24 hour notice must be paid for in full. This is also true if you fail o notify me that cannot attend an appointment.

Client initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Establishing the Therapeutic Alliance:** In order for therapy to be successful, it is important that both client and therapist fee the relationship is compatible. Therefore, the client and I will evaluate the therapeutic alliance on a regular basis and decide if the match appears appropriate to contain the conditions necessary for successful treatment. If the therapeutic alliance does not appear to be the best for you, I will provide referrals for other therapists and/or psychiatrists.

Client initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Rights:** In addition to confidentiality, as spelled out above, you have the right to end your therapy at any time, for whatever reasons, without any moral, legal or additional financial obligation except for the fees already incurred. You have the right to question any aspect of your treatment with me and to expect that I will work with you to meet your needs for adjunctive or alternative treatment. You also have the right to expect that I will maintain professional and ethical boundaries by not entering into another personal relationship with you. All of which would greatly compromise our work together.

Client initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THERAPIST RIGHTS AND RESPONSIBILITIES**

It is my responsibility to provide you with informed, respectful, and competent care in accordance with the highest of ethical and legal standards. I request the same safe, respectful treatment you can expect from me. I may also exercise the following rights:

**Consultation:** I may seek consultation with other professional colleagues as needed in order to provide the most appropriate and effective services to you. Such consultation will not involve your name or specific information unless we have first discussed the need for this, and you have provided written permission to do so.

Client initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Termination of Treatment:** If I feel that services I can offer are not, or will not be appropriate for you, I may, after discussing reasons with you, refer you to another provider or agency. Furthermore I reserve the right to terminate services if treatment recommendations are not being followed. Such situations include but are not limited to: if payment is not timely, if recommended consultations are not sought, if medication is not taken as prescribed for mental health continuity, if dangerous practices are continues or if sessions are attended after consuming drugs or alcohol.

Client initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Services:** I do not generally provide after-hours emergency care. However, in an emergency, you may call the office and I will return the call if I am available. In the case of an emergency during which I cannot be reached, please dial 911, go to the nearest hospital or the USA National Suicide Hotline at 800-784-2433.

Client initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AGREEMENT GOT PSYCHOTHERAPY CONSULTATION AND TREATMENT**

I have read this informed consent completely and have raised any questions I might have. I have received full and satisfactory responses and agree to the provisions freely.

If I am consenting for a minor I acknowledge the laws and guidelines pertaining to treatment for a minor that have been reviewed by the therapist. I will provide any requested documentation and will continue to remain in contact with the therapist when necessary.

I understand that Talyn Olguin is responsible for maintaining all professional standards set forth in the ethical principles of her professional association as well as the law as of the same California governing the practice of psychotherapy.

I understand that I will be fully responsible for any and all legal and/or collection costs arising as a result of my contact with Talyn Olguin.

The agreement constitutes the entirety of our professional contract. Both parties must sign for any changes, I have a right to keep a copy of this contract.

Client’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicable:

Legal Parent or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Parent or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_