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INFORMED CONSENT FOR PSYCHOTHERAPY

GENERAL INFORMATION

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

THE CLIENT & THE INSURED

The Client is referred to as the primary person receiving therapy. When insurance is being used, The Insured is the person financially covering the treatment of therapy. Typically, this is the same person; however, in circumstances where The Client and The Insured are different individuals, the confidentiality of the The Client's treatment will be enforced in all circumstances, except those listed below. Please note that the Insured will receive any documentation sent by the Insurance company and not the Client (if different).

In the case where The Client is the minor, The Client's confidentiality will be enforced in all circumstances, again except for those listed below. If you are divorced, separated, or currently involved in any legal proceedings, you must submit a hard copy of your custody decree that documents that you have the legal right to seek treatment for you child.

THE THERAPEUTIC PROCESS

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

CONFIDENTIALITY

The waiting room located at this address is monitored by a security camera that is video and audio recording for safety reasons at all times. The video footage remains confidential, except in the case of an emergency, in which case the video and audio footage may be released to Ring Alarm Company, Fresno PD and/or other law enforcement agencies, the landlord, and/or this Clinician. An emergency constitutes danger/threat to the physical property or body of anyone that enters or stands within video recording distance of this waiting room.

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. In cases where an Insurance is being used to finance the treatment, please know that your Insurance is also required to to receive information regarding your treatment, diagnosis, progress, and any other information required of the Insurance company in order to approve reimbursement. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.
Additionally, in the event of any items listed above where your welfare or that of another person or their property is in question, a welfare check by law enforcement will be requested.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.
If you are not comfortable with any part of this Consent form, please contact me by phone or email so that we can discuss your concerns further. If necessary, I may refer you to another provider that may better fit your needs.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

CLIENT: _____

DATE:_____