

### **Informed Consent for Psychotherapy**

**THE THERAPY PROCESS:** Your therapists' top priority is to provide you with services to help you reach your mental health goals, but your therapist can not guarantee any specific outcome. Your therapist will work with you to develop a treatment plan and will regularly collaborate with you in discussing treatment progress.

**CONFIDENTIALITY:** All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.

**EXCEPTIONS TO CONFIDENTIALITY:** Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to your therapist that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you.

**AUTHORIZATION TO RELEASE INFORMATION:** There are times when you may want your therapist to be able to communicate with a third party such as a doctor, a psychiatrist, a family member, etc. In this case you must complete and sign an Authorization to Release Information. If you are involved in family or couples therapy, it must be signed by all adult parties who were part of treatment (or all those who legally can authorize such a release).

**FEE & INSURANCE REIMBURSEMENT:** The fee for each 50-minute session is \$130 dollars and is payable at the beginning of each session. Site visits, letter writing and lengthy phone calls will be charged per 15-minute intervals of the aforementioned rate, unless otherwise arranged. Clients who use their insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. It is your responsibility to verify the specifics of your coverage. Your therapist can provide you with a receipt on a monthly basis which you can use to submit to your insurance carrier for reimbursement.

**HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS:** Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/EAP in order to process the claims. Your therapist will communicate only the minimum necessary information to the carrier. However, some insurance companies state that they also retain the right to request clinical notes. Your therapist will inform you should they receive such a request.

**CANCELTATION:** Please provide at least 24 hours' notice if you need to cancel or reschedule your appointment for any reason. Cancellations within less than 24 hours' notice will require a late cancellation fee of \$130 which is the full fee per session, unless otherwise agreed upon.

**RECORDS AND YOUR RIGHT TO REVIEW THEM:** Your therapist is required to keep treatment records for at least 7 years. As a client, you have the right to review or receive a summary of your records. However, your therapist must protect your health information and your well being and will use their clinical judgement in responding to requests for records. When more than one client is involved in treatment, such as in cases of couple and family therapy, your therapist will release records only with signed authorization from all the adults (or all those who legally can authorize such a release) involved in treatment. Your therapist may request up to 10 days in order to provide requested information.

**TELEPHONE & EMERGENCY PROCEDURES:** Your therapist can be reached at 510-292-1766 and you may leave a confidential voicemail. Your therapist checks voicemail messages daily and can usually return phone calls within 24 hours Monday – Friday only. If you need to speak to someone urgently you may call Crisis Support Services of Alameda County at 1-800-273-8255 available 24 hours 7 days a week. However, if you are experiencing an emergency please go to your local emergency room or call 911. **My therapist can call, text and leave messages for me at:**

**EMAIL POLICY:** You may email your therapist at [gina@ginafahourilmft.com](mailto:gina@ginafahourilmft.com) with non – urgent issues. Your therapist checks their email several times a week and can usually respond to your email within 48 hours Monday – Friday only. Please do not use email communication for urgent or emergency issues as your therapist can not respond promptly. While your therapist

uses a HIPAA compliant email service, your therapist recommends that you do not include highly personal information in your email as email communication poses certain risks. Some of these risks include, but are not limited to, interception while in transit, email being sent to incorrect addresses and introducing viruses to your computer. If you need to speak to someone urgently you may call Crisis Support Services of Alameda County at 1-800-273-8255 available 24 hours 7 days a week. However, if you are experiencing an emergency please go to your local emergency room or call 911. **My therapist can email me at:**

**CONSULTATION:** Your therapist consults regularly with other professionals regarding treatment for their clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained.

**ENDING SERVICES:** Your therapist will encourage you to identify how you will know you have met your goals and a plan for successfully ending services. However, you may end services at any time you decide. If your therapist finds that services are not providing sufficient benefit, they will discuss this with you and suggest alternative treatment options.

**NOTICE TO CLIENTS:** The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at [www.bbs.ca.gov](http://www.bbs.ca.gov), or by calling (916) 574-7830.

I have read the above Informed Consent for Psychotherapy carefully (a total of 4 pages) and I understand them and agree to comply with them:

**Client's Name (print)** \_\_\_\_\_

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

Gina Fahouri, LMFT #43893

**Parent/Guardian Name(print)** \_\_\_\_\_

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

**Psychotherapist's Name (print)** \_\_\_\_\_

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