

Allison Waite, M.A., LMFT
Licensed Marriage and Family Therapist LMFT#100610
1001 Dove Street • Suite 260 • Newport Beach • CA • 92660
(949) 630-5592

INFORMED CONSENT FOR ASSESMENT AND PSYCHOTHERAPY

Your Name: _____

Welcome this document contains important information about my professional services and business policies. Please read it carefully. We can discuss any questions you have about the procedures at anytime.

Appointments

The “assessment/counseling hour” is approximately 50 minutes. The remaining time is allotted for telephone contacts and paperwork. I understand emergencies may arise that might necessitate your not being able to attend our scheduled appointment. If you need to cancel an appointment, please provide *at least* 24 hours notice. All appointments not cancelled 24 hours in advance will be charged at **full fee**.

Phone calls

There may be times you need to speak to me between sessions. I am available by phone, and request that you limit your call to 10 minutes, or if more time is needed, schedule a separate, emergency phone session. I check my messages often, but it may 24 hours before I can get back to you. It is important, therefore, that when you leave a message, you also leave the best times to reach you and additional phone numbers, if necessary. **EMERGENCIES:** In the case of physical, emotional or psychological emergency dial 911 or proceed to the nearest emergency room.

Contacting Me

I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voicemail and your call will be returned as soon as possible. **PLEASE NOTE, TEXTS AND EMAILS ARE NOT SECURE METHODS OF COMMUNICATION. I RECOMMEND TEXTS BE USED ONLY TO SCHEDULE, CANCEL OR CHANGE AN APPOINTMENT. I MAY NOT RESPOND TO AN EMAIL OR TEXT FOR ANY NUMBER OF REASONS AND THEREFORE DO NOT RECOMMEND ITS USE.**

Fees

Our agreed upon fee for the therapy hour is \$185.00. Fees are payable at the time of service. I accept checks, cash and credit card. Please notify me if any problems arise during the course of treatment regarding your ability to make timely payments. All returned checks will incur a \$20 service fee.

If you have health insurance

If you have a health insurance policy, please be sure to contact your insurance representative to verify coverage and to obtain information about your coverage. I will provide you with a receipt for sessions suitable to be presented to your insurance carrier. You may submit this receipt for

services to your insurance company for reimbursement along with the applicable claim form. Professional services are rendered and charged to the patient not the insurance company.

Confidentiality

All information disclosed within sessions is confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.

Disclosure may be required under the following circumstances: where there is reasonable suspicion of child or elder abuse or neglect; where there is reasonable suspicion that the client presents a danger of violence to others; where the client is gravely disabled; or where the client is likely to harm her/himself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding, such as a collection of unpaid fees through a collection agency or small claims court. There are also certain circumstances under the Health Insurance Portability and Accountability Act (HIPAA) regarding disclosure of your protected health information; details are outlined in the accompanying form titled, "Notice of Privacy Practices". With the exception of required disclosures, if it is necessary for me to speak with another person regarding your treatment, a signed consent form is required

Process of Therapy/Evaluation

Our first few sessions will involve a history taking evaluation. This can last from one to five sessions. During this time, we can both decide if I am the best professional to provide the services you need in order to meet your treatment goals. You have the right to terminate treatment at any time. If either of us believes it is not in your best interest to continue treatment with me, termination will occur and you will be provided with three names of qualified professionals.

Participation in therapy can result in a number of benefits to you, including, improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working towards these benefits requires effort on your part, including your active involvement, honest and openness. During evaluation or therapy, remembering or talking about unpleasant events, feelings or thoughts can result in your experiencing considerable discomfort and strong feelings. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy I am likely to draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you, including behavioral, cognitive, psychodynamic, systems/family, developmental, psycho-educational approaches and eye movement desensitization and reprocessing.

I may make referrals pertaining to your health and safety. This informed consent, and other written requests that I may make pertaining to your health and safety, must be agreed to and complied with in order to continue on-going psychotherapy. If you choose not to comply with any referrals, which are designed to safeguard you or the therapy process, therapy may be terminated.

Litigation Limitations:

Due to the nature of the therapeutic process and the fact that it often involves making full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be a legal proceedings, neither you nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the

psychotherapy records be requested. If you become 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 by you or the other party.

Emotional Support Animal Letters:

Due to a potential conflict of interest, I cannot provide emotional support letters but will refer you to a neutral, third party professional or therapist.

Arbitration Agreement

I agree to submit any disagreement regarding services or complaints regarding breaches in law or ethics to binding arbitration under the auspices of the American Arbitration Association located in Irvine, CA. I agree to pay any and all legal costs arising from complaints that are not fully validated by the arbitrator. I agree to pay legal fees incurred by the therapist as a result of these sessions.

Independent Practice

I understand that Allison Waite is a sole proprietor and not in a joint business relationship with any other Counseling Offices or Treatment Centers. As such, Allison Waite has no liability for the actions of any other therapist or person connected with any Counseling Offices or Treatment Centers. Conversely, any recourse against Allison Waite for actions taken by her is personal to her and in no way affects any other therapist or person connected with any Counseling Offices, Sober support staff or Treatment Centers.

Your signature below indicates that you have read and understand this agreement and agree to its terms.

Client/Guardian Signature(s) _____ Date

Client/Guardian Printed Name(s) _____

