



INFORMED CONSENT

Introduction: This agreement is intended to provide you with important information regarding the practices, policies and procedures of THE FAMILY GUIDANCE AND THERAPY CENTER OF SOUTHERN CALIFORNIA and to clarify the terms of the professional therapeutic relationship between your therapist, _____ and you/your family. If you are a parent of a minor client, then you will need to consent to their treatment prior to the commencement of services. Any questions or concerns regarding the contents of this Agreement should be discussed prior to signing it. Please read the entire document carefully and ask any questions before signing the document. Please initial each section to indicate that you have read and understood that particular section.

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Practice Information: The individual marital and family therapist who operates this practice is Jennifer Palmiotto. Her license number is #47375. This practice is a Licensed Marriage and Family Therapist Corporation: THE FAMILY GUIDANCE AND THERAPY CENTER OF SOUTHERN CALIFORNIA. This professional corporation operates under the fictitious business name of THE FAMILY GUIDANCE AND THERAPY CENTER OF SOUTHERN CALIFORNIA.

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Therapist Background and Qualifications: At your request, I will discuss my professional background information with you and provide you information regarding my experience, training, special interests, and professional orientation. You are free to ask questions at any time about my background, experience and professional orientation.

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Professional Services Rendered: The Family Guidance and Therapy Center of Southern California offers several services including psychotherapy. Psychotherapy may involve one individual, the whole family, couples, or group therapy, RDI consultation, educational and behavioral services.

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Process of psychotherapy: There are many reasons that people come to therapy. Therapy will include an initial assessment, treatment planning, and face-to face sessions. Before treatment begins, we will determine who needs to attend sessions. Depending on your individualized treatment plan, we may work on improving communicate, solving problems, developing or strengthening coping strategies, learning to maintain positive interactions, practicing techniques, parent training, or self-exploration. All

therapy will promote healthier and more satisfying relationships. I use a variety of interventions including dialogue, expressive arts, imagery, role playing, homework assignments, along with other modalities and interventions. Clients can at any time ask questions about their treatment.

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Risks and Benefits of Therapy: Psychotherapy is a process in which we discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so clients can experience life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties clients maybe experiencing. Psychotherapy is a joint effort between the client(s) and the therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Participating in therapy may result in a number of benefits, including, but not limited to, reduced stress and anxiety, increased ability to relate to others, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in school, social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of the client(s), including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above. Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which clients perceptions and assumptions are challenged, and different perspectives offered. The issues presented by clients may result in unintended outcomes, including changes in personal relationships. Clients should be aware that any decision on the status of his/her personal relationships is your responsibility. During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. You may address any concerns you have regarding progress during your session. If you are the parent/representative of a client, there are limits to what will and will not be discussed in the course of treatment. These expectations will be clarified with your be-fore treatment begins.

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Professional Consultation: Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personal identifying information concerning clients.

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Records and Record Keeping: I will keep records in accordance with the ethical and legal standards of my profession. Records may be re-requested at any time in writing. Records will be stored in a locked file cabinet or by a secured on-line practice management software system. Records will be kept for 7 years after you've terminated therapy.

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Use of Practice Management Software: MyClientsPlus software is fully secure, confidential, encrypted, HIPAA-compliant practice management software.

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E-mails, Cell Phones, Computers and Faxes: It is very important to be aware that computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. While data on FGTC providers' laptops is encrypted; e-mails and e-fax are not. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and computers. FGTC providers' laptops are equipped with a firewall, a virus protection and a password, and providers back up all confidential information from their computers on a regular basis onto an encrypted hard-drive. Also, be aware that phone messages are transcribed and sent to FGTC providers via unencrypted e-mails. Please notify your FGTC provider if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, FGTC will assume that you have made an informed decision, and will view it as your agreement to take the risk that such communication may be intercepted, and FGTC will honor your desire to communicate on such matters. Initial below if you consent to to communicate by email, text and voicemail. *Please do not use texts, e-mail, voice mail, or faxes for emergencies.*

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Participation in Litigation: I will not voluntarily participate in any litigation, or custody dispute in which client and another individual, or entity, are parties. I have a policy of not communicating with client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in a legal matter unless agreed upon at beginning of the therapeutic relationship. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving a client, client agrees to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate of \$150.00/hour.

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Psychotherapist-Patient Privilege: The information disclosed by client, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and client in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. If I received a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-patient privilege on client's behalf until instructed, in writing, to do otherwise by client or client's representative. Client should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Client should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

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Notice of Privacy Practices: This practice is HIPAA compliant. Please indicate that you have received and signed the document named "Notice of Privacy Practices." This document further explains how your medical information will be used by this practice.

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Confidentiality: All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release.

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Exceptions to confidentiality: There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

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Minors and Confidentiality: Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who consented for their child's treatment are often involved in their treatment. Within my professional judgment, I will discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

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Fee and Fee Arrangements for Psychotherapy: The usual and customary fee for psychotherapy and educational service is _____/hour. Your appointment will be for _____ minute session. An additional _____ minutes will be used for record keeping. Sessions longer than your scheduled appointment are charged for the additional time pro rata. I reserve the right to periodically adjust this fee. You will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payers. From time-to-time, I may engage in telephone contact with you for purposes other than scheduling sessions. You will be responsible for payment of the agreed upon fee on a pro rata basis. In addition, from time-to-time, I may engage in telephone contact with third parties at client's request and with client's advance written authorization. Client is responsible for payment of the agreed upon fee (on a pro rata basis). Clients are expected to pay for services at the time services are rendered. Cash, credit card, or checks are accepted.

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Return check Policy: You be responsible for the amount of any returned checks plus a \$15.00 returned check fee which includes bank fees and administrative costs.

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Cancellation Policy: You are responsible for payment of the agreed upon fee for any missed session(s). You are also responsible for payment of the agreed upon fee for any session(s) for which you failed to give at least 24 hours' notice of cancellation. Cancellation notice should be left on company voicemail at 619-600-0683.

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Therapist Availability: My office is equipped with a confidential voicemail system that allows a client to leave a message at any time. You may contact me at 619-600-0683 ext _____. I will make every effort to return calls within 24 hours (or by the next business day), but can-not guarantee the calls will be returned immediately. I am unable to provide 24-hour crisis service. In the event that client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room. In the event that I am unable to attend our scheduled appointment, I will contact you via your preferred method of communication to cancel and re-schedule the session. You will be notified in advance of vacations or planned extended absences. You and I will determine a revised treatment plan prior to the absence.

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Use of Telemedicine: This practice uses telemedicine as part of treatment. Telemedicine includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications, and e-mail. Telemedicine also involves the communication of your medical/mental information, both orally and visually, to health care practitioners located in California or outside of California. You have the following rights with respect to telemedicine: (1) you have the right to with-hold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any pro-program benefits to which I would otherwise be entitled. (2) The laws that protect the confidentiality of your medical information also apply to telemedicine. As such, the information disclosed by you during the course of your therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where you make your mental or emotional state an issue in a legal proceeding. The dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your written consent. (3) There are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of your psychotherapist, that: the transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your medical information could be interrupted by unauthorized persons; and/or the electronic storage of your medical information could be accessed by unauthorized persons. In addition, please understand that telemedicine based services and care may not be as complete as face-to-face services. I will advise you if you would be better served by another form of psychotherapeutic services (e.g. face-to-face services). You will be referred to a psychotherapist who can provide such services in your area. Finally, there are potential risks and benefits associated with any form of psychotherapy, and that despite your and my efforts, your condition may not be improve, and in some cases may even get worse. (4) You may benefit

from telemedicine, but that results cannot be guaranteed or assured. (5) You have a right to access your medical information and copies of medical records in accordance with California law. You may discuss the use of telemedicine with me at any time.

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Termination of Therapy: You may terminate therapy at any time. I, also, reserve the right to terminate therapy at my discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, client needs are outside of my scope of competence or practice, or client is not making adequate progress in therapy. You also have the right to terminate therapy at your discretion. Upon either party's decision to terminate therapy, I will generally recommend that client participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. I will also attempt to ensure a smooth transition to another therapist by offering referrals to client, if requested.

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Questions or Complaints: If you have any questions about this no-tice or any complaints about my privacy practices, or would like to know how to file a complaint with the Board of Behavioral Sciences or the Secretary of the Department of Health and Human Services, please contact me at: The Family Guidance & Therapy Center of Southern California, 3555 Kenyon Street, Suite 101, San Diego, CA 92110 to discuss your concerns.

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Acknowledgement: By signing below, client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Client has discussed such terms and conditions with their therapist and has had any questions with regard to its terms and conditions answered. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy or other services with Therapist. Moreover, client agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____ Initial

I, _____, have read this Informed Consent document, I understand it and agree to comply.

Child/Minor Name (If applicable)

Printed Parent/Guardian Name

Relationship to Client

Signature

Date