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CA License # MFC 40277
Psychotherapy

Informed Consent, Office Policy and Legal Engagement Form

Welcome to my psychotherapy practice!
This form provides you with information about the process of therapy and the policies of my office. This is an important and informative document. I ask you to read it thoroughly and to keep a copy of it for your records. I welcome any questions you may have about it.

RISKS AND BENEFITS OF PSYCHOTHERAPY: Psychotherapy is a choice. Helping you define and achieve therapeutic goals is the purpose of our collaborative work. Psychotherapy often involves learning about yourself – how to recognize, tolerate and respond to your emotional needs – and about the way you relate to other people. Psychotherapy has both benefits and risks. The risks may include experiencing uncomfortable feelings such as sadness, anxiety, confusion or frustration. These feelings typically occur as a result of your discussing difficult aspects of your life, and they are a typical response to the process of therapy. The benefits are that it often leads to significant reduction of distress, a stronger sense of who you are, enhancement of relationships, closure of un-mourned experiences, and resolution of conflicts.

It does require consistent effort and a desire to change on your part. Your role will be to speak openly about your thoughts, feelings or symptoms at your own pace. I will be listening, asking questions, and offering new ways to look at or think about your experiences. If appropriate, I may also recommend that you seek additional services. For some people that means a consultation with a psychiatrist for medication, psychological testing, a visit to your primary care physician, or a support group. You may end psychotherapy at any time, but I would like to encourage you to bring up any thoughts you might have about the future of our sessions anytime.

OUR FIRST SESSION: The first few sessions typically involve an evaluation of your needs through gathering detailed information. By the end of the evaluation, I will offer you some initial impressions of what our work will include. It is important for you to evaluate this information as well as your level of comfort in working with me. Therapy involves commitment of time, money and energy, so it is crucial that you select a therapist with whom you can connect. If, through this initial evaluation either of us feels that we are not the best match, or that you need another type of service, I will help you with referrals.

LENGTH AND FREQUENCY OF SESSIONS: Your therapy schedule – the length and frequency of your sessions – will depend upon many factors, including your level of distress, individual preferences, time limitations, and financial concerns. We will determine an initial plan and make adjustments as we go along, if needed. I offer 50-60 minute sessions on a twice-a-week, once-a-week and every-other-week basis, depending on our fee agreement and/or your insurance coverage. If you are late, we will end on time. If I am late, you will still receive 45 - 55 minutes of my time for the session. This may be provided during that session period, or added to another session at a later date.

EMERGENCY PROCEDURES: If an emergency situation arises, I advise you to call 911 or go to the nearest hospital/ER. If you need to speak to me urgently (but it's not an emergency) and you cannot get a hold of me right away, call the crisis access line at **(888) 724-7240** at any time of the day or night.

CONTACTING MY OFFICE: You may leave messages for me at any time at (619) 944-2375. During the week, will return your message within 24 hours of your call. I check my messages at the end of my working day, and return calls up until 7 PM Monday through Thursday, unless I am out of town. Messages left after 7 PM Monday through Thursday will be returned on the following day. Messages left after 4PM on Friday are returned the following weekday.

Name:____________________________Initials: ________________

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

I am legally required to disclose confidential information if you indicate that you seriously intend or plan to hurt yourself or another person, or if your condition is such that you are gravely disabled. When there is a reasonable suspicion of child, elder or dependent adult abuse or neglect, these suspicions must be reported. While it is my legal responsibility to report these incidents, I will support you through this challenging time in the event that these issues arise.
These are situations when disclosure of confidentiality MAY be required:

- If you place your mental status at issue in litigation initiated by you, in that case, the defendant may have the right to obtain your psychotherapy records and/or my testimony.
- In couples or family therapy, confidentiality and privilege do not apply between the parties. I'll use my clinical judgement when revealing such information and I won't release any records to outside parties unless I'm authorized to do so by "all" parties involved in treatment. 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.
- Emergency: If there is an emergency during our work together and I become concerned about your personal safety, or the possibility of you injuring someone else, or about you receiving appropriate psychiatric care, I'll do whatever I can within the limits of the law to keep you and others safe. In these situations, I may need to contact the person whose name you have provided as an Emergency Contact on your biographical sheet.
- 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. Please refer to the Federal Health Insurance Portability and Accountability Act (HIPAA) form on my website with regard to the use and disclosure of your Protected Health Information (PHI). Only the minimum necessary information will be communicated to the carrier. By signing this contract, you are consenting to a release of information about your case to your health plan for claims, certification and case management for the purposes of treatment and payment. I have no control or knowledge over what insurance companies do with the information I submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance.
  I have reviewed and understand Jacqueline Smith, LMFT HIPAA policies ________________________

CONSULTATION: I regularly consult with other professionals regarding my clients; however, a client's name or other identifying information is never mentioned. The client's identity remains anonymous; confidentiality is maintained.

RECORDS AND RECORD KEEPING: I may take notes during our sessions and will produce other notes and records regarding your treatment. These notes constitute my clinical and business records, which by law, therapists are required to maintain. Such records are sole property of the therapist. I will not alter my normal record keeping process at the request of any client. Should a client request a copy of my records, such a request must be made in writing. I reserve the right, under California law, to provide my clients with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. I will maintain my clients' records for ten years following termination of therapy. After the ten years, your records will be destroyed in a manner that preserves confidentiality.

INFORMED CONSENT FOR ELECTRONIC (EMAIL/TEXT/FAX/PHONE/SKYPE) CONTACT: Ordinary privacy precautions such as voice scramblers, pin codes, voice mail boxes, and locked fax, even regular mail, and computer rooms are by no means foolproof, so that your confidentiality is always compromised when communicating by electronic devices or mail. Nor is deletion or shredding of private material a totally safe means of disposal, so that you are always at risk of breaches in confidentiality when electronic or mail communication of any type is used for private information. Your

use of such means of communication with me constitutes implied consent for reciprocal use of electronic and mail communication as well. By signing this contract, you agree to and understand the following:

1. Many people feel comfortable communicating via email, because they have installed programs designed to detect spyware, viruses, or other dangerous software. However, there is no guarantee that such programs will work 100%.
2. Sent and received texts/emails are stored on both mine and your phone/computer until deleted. I may or may not delete such texts/emails. Any saved texts/emails will be kept in a password-protected account that only I access.
3. Emails and texts should be used only to arrange or modify appointments, for invoice or to ask billing questions. Please do not email or text me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.
4. Some people have inquired about having a Skype session when they are travelling on business or vacation. First it is important to note that if you are utilizing insurance to cover your treatment, all insurance companies I work with will not pay for electronic therapy sessions, only office visits. If it is your choice and our agreement to use such technology, it is crucial that you know that, for the same reasons described above, the video of our sessions would be stored in cyberspace and could be accessed, in theory, by system administrator(s) of the internet service provider.
5. Email and texting have become a quick way to reach people out. As it pertains to my private practice, I maintain the same time frame of telephone contact (see above description) – I'll check the messages throughout the day, and try my best to contact you, but, on occasion, your message may be returned at the end of my working day.

By signing below, I agree that I understand the disclosures listed above regarding communicating with Jacqueline B. Smith, LMFT using text/email. I also agree that if I send a text/email to her and request a response via text/email, I am willing to accept the above-stated risks. **I agree that I will not use text or email for emergencies**.
Name:____________________________Signature______________________________Date:_________
Sign if you give your permission for Jacqueline B. Smith, LMFT to initiate sending text/emails to you.
Name:____________________________Signature______________________________Date:_________
Print your email clearly:____

PAYMENT INFORMATION:

- Psychotherapy fee: My standard fee is $170 per session. You are expected to pay the agreed fee of ________ at the beginning of each appointment, unless other arrangements have been made. All payments are to be made in the form of cash, check or Zelle, money transferring.

- Insurance: If you are utilizing insurance to pay for your treatment, you are responsible for any applicable deductibles and co-payments at the time of service. Insurance carrier:______________and your co-pay/co-sharefee:________. **By signing this contract, you agree that if you have not obtained all necessary authorizations from your insurance, or are not eligible at the time services are rendered, you are responsiblefor payment even if the determination is made after the services are rendered**. If payments are not made, I reserve the right to utilize a collections agency for means of collecting the payment.

- Returned checks: In the event of a returned check for insufficient funds, you will be charged $25 *in addition* to the amount of the check to cover banking fees. Please do not hesitate to notify me if any problem arises during the course of therapy regarding your ability to make timely payments.

- Treatment Summaries: The writing of simple treatment summaries for individual or couples treatment will include solely the information regarding number of sessions attended, frequency of sessions, treatment goals and progress. The fee is $150 paid in advance.

- Preparation of business and clinical records to the court will be charged at $200 per hour, with the agreement of a minimum 1 ½ hours: $300 paid in advance.

- Phone consultations regarding legal proceedings: A minimum of one-hour fee will accrue for any kind of phone consultation.

- Depositions, court appearances or other testimony: Depositions, court appearances or other testimony by the therapist in proceedings regarding you, whether requested by you or others, will accrue the following fees:
    1. $1,000 (one thousand dollars) for up to four hours of the therapist's time in preparing for the Deposition, court appearances or testimony, which fee shall be paid at least two weeks in advance of the appearance date.
    2. $1,000 (one thousand dollars) for up to four hours of the therapist's time in attending or testifying in person at a Deposition or court appearance, which fee shall be paid at least two weeks in advance of the appearance date.
    3. $250 (two hundred and fifty dollars) for up to one hour of the therapist's time in being available on call or testifying by phone, which fee shall be paid at least two weeks in advance of the appearance date.
    4. Time expended by the therapist in excess of the above, shall accrue fees of $250 (two hundred and fifty) per hour.

    * All fees shall be earned regardless of whether the therapist is actually called to testify, or whether the Deposition or Court proceedings are cancelled or rescheduled.

CANCELATION POLICY: Occasionally it may be necessary for you to miss a session (for example, people get sick, or have an unplanned work meeting or trip.) If you are unable to keep an appointment, please notify my office immediately. I will do my best to reschedule it for you. Since a consistent therapy schedule involves the reservation of time specifically for you, **a minimum of 24 hours' notice is required for rescheduling or cancelling your appointment. You will be charged $100 for sessions missed without such notification, regardless of the reason of your cancelation**.The insurance companies I work with do not reimburse for missed sessions, so I will not provide you with a billing statement in case of missed sessions. **I understand the cancelation policy: ________________**

LITIGATION LIMITATION: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be confidential, it is agreed that should there be legal proceedings (for example, divorce custody disputes, lawsuits, injuries, divorce, etc.), neither you (the client) nor 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.

MEDIATION AND ARBITRATION: By signing this office policy contract, you are agreeing that all disputes arising out or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by our mutual agreement, and the costs of such mediation shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in San Diego County, California in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Lawsuits are something that no one anticipates and everyone hopes to avoid. The method of resolving disputes by arbitration is one of the fairest systems for both patients and psychotherapists. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts. You may still call witnesses and present evidence. Each

party selects one arbitrator, who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement typically helps to limit the legal costs for both patients and psychotherapists. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings. My goal, of course, is to provide psychotherapy care in such a way as to avoid any such dispute. I know that most problems begin with communication. Therefore, if you have any questions about your care, please ask.

TERMINATION OF THERAPY: As a therapist, I reserve the right to end therapy at my professional 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, when client's needs are outside my scope of competence or practice, or when client's is not making adequate progress in treatment. Clients have the right to terminate therapy at their discretion. Upon either party's decision to terminate therapy, I will generally recommend that you participate in one, or possibly more, termination sessions. These sessions are aimed at facilitating positive closure and give both parties an opportunity to reflect on the work that has been done. At that juncture, I will also attempt to ensure a smooth transition to another therapist by offering referrals.

I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with them:

____Date:_____________
Signature of Client (1)

____
Printed Name

____Date:_____________
Signature of Client (2)

____
Printed Name

____Date:_____________
Clinician's signature