SP
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CLIENT INFORMATION AND CONSENT FORM

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read, initial each page in the bottom right hand corner, and sign at the end stating you have fully read, understand, and acknowledge the information below.

AVAILABLE SERVICES: Sandy P. Pedram, Esq., LMFT, BBS 107429 ("Therapist") is a licensed California Marriage and Family Therapist, offering a wide array of counseling services, including individual, family, couples, group, and mediation services. You are free to ask questions regarding your therapist's background, education, experience, and professional orientation at any time. While Sandy P. Pedram Esq., LMFT is a lawyer, mediator, and psychotherapist, for legal and ethical reasons, she neither provides her psychotherapy/mediation clients with legal advice nor serves as psychotherapy/mediation clients' attorney.

CLIENT/THERAPIST RELATIONSHIP: I understand that Therapist and I have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. Moreover, due to the varying nature and severity of problems and the individuality of each client, Therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result. Attempting to resolve issues that brought you to therapy may result in changes that were not originally intended. The benefits of counseling can, however, far outweigh any discomfort or other risks encountered during the process, including but not limited to improving interpersonal relationships, reducing feelings of emotional distress, improving social and/or occupational functioning, and resolving concerns that led you to seek therapy. I understand that working toward these benefits, however, requires effort, active involvement, honesty,

and openness on my part. I understand that the outcome of my treatment will largely depend on my willingness to engage in this process.

COUNSELING: Therapist provides counseling designed to address many of the issues clients are dealing with. Initial sessions will involve an assessment process in which you and Therapist will determine your concerns and work collaboratively to develop a corresponding plan for treatment. I understand that should I choose not to follow the treatment plan, miss/cancel multiple sessions, and/or it be questionable whether I am benefiting from treatment, Therapist reserves the right to terminate my services**.**

YOUR RIGHTS: While Therapist's goal is to provide effective, efficient treatment, services are at all times voluntary. I understand that if at any time I feel that Therapist and I are not a good fit or for some reason find that I am unable to continue paying for therapy, I will discuss this matter with my therapist to determine if I am better suited transferring to a different service provider. Please feel free to speak to Therapist about any/all of your concerns. Therapist appreciates feedback informed care and will make every effort to resolve issues. In the alternative, Therapist will provide appropriate referrals to assist with connecting me to a provider that meets my needs. I understand that, as an individual receiving services from Therapist, I have the right to: be treated with dignity and respect; receive treatment regardless of race, religion, sex, age, ethnic background, mental and/or physically disabling condition; be provided confidentiality and protection from any unwarranted disclosure regarding my treatment; be involved in planning my treatment and be informed about my treatment process; be involved in my discharge and aftercare planning; refuse treatment to the extent permitted by law; be informed of the possible consequences of my actions; expect continuity of care from one service to another, should I need another service; and examine and receive an explanation regarding fees for my services. I understand that I have the right to review or receive a summary of my records per advanced written request, except in limited legal or emergency circumstances or when Therapist assesses releasing the information might be harmful. 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. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

APPOINTMENTS AND FEES: I understand that my fee, as agreed upon with Therapist, will be **$225 per 50 minute session**. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. I understand that fees, including any required co-pays, are payable prior to the beginning of my session and that I shall pay owed amount each time I come in for a session. Sessions are typically scheduled once per week, depending on the nature and severity of my concerns. I understand that my consistent attendance greatly contributes to a successful outcome. I understand that **all appointments must be cancelled at least 48 hours in advance, so that Therapist may fill the hour with another appointment. If I do not cancel a session 48 hours in advance, I agree that I will be charged $225 to my credit card/other form of payment on file. I also understand that I must be within the state of California for telehealth sessions and arrive promptly at my scheduled time. I agree that if I arrive ten or more minutes past my scheduled time and/or out of the state of California, our session will be cancelled and I will be charged $225 to my credit card/other form of payment on file. This policy is necessary because a professional time commitment is set aside and held exclusively for me. If I miss two consecutive appointments, I understand that it is likely that I will lose my regular appointment time and my case may be closed**. I understand that there will be a regular review of my fee with my therapist twice a year at which times my fee might be adjusted. If I do not pay promptly and accumulate a balance equal to twice my weekly fee, I must make and adhere to a plan for payment or therapy will be stopped until the balance due is paid. If I terminate therapy or therapy ends because of an accumulated balance, I understand that Therapist may use a collection agency to collect the unpaid balance. In addition, I understand that I will be charged $25 per a returned check and a reasonable fee for copies of any record requests.

TELEHEALTH: Telehealth includes the provision of services through electronic means, with Therapist in one location while you, the client, are in

a different location. Services by electronic means may include but are not limited to telephone communication, the Internet, facsimile machines, and e-mail. If you and Therapist choose to use information technology for some or all of your treatment, you retain the option to withhold or withdraw consent at any time. Telehealth has both benefits and risks, which you and Therapist will be monitoring. It is possible that receiving services by telehealth will turn out to be inappropriate for you and that Therapist may need to cease telehealth with you. Potential benefits of using telehealth include but are not limited to improved communication capabilities, easier access to therapy, support, continuity of care, and reduction of lost work time/travel costs. Potential risks include but are not limited to technical issues/failures, interruption by unauthorized persons, unauthorized access to transmitted and/or stored confidential information, clinical limitations, and Therapist's reduced ability to directly intervene in crises or emergencies. Therapist follows security best practices and legal standards in order to protect your health care information, but you will also need to participate in maintaining your own security and privacy, such as by creating an appropriate space for your telehealth sessions that is safe and confidential. You will also need to participate in making a plan for managing technological failures, health crises, and medical emergencies in conjunction with the use of telehealth. I confirm that I have read, understand, and agree to the terms and conditions of services via telehealth.

PAYMENT/INSURANCE: I agree that I am responsible out of pocket for any/all fees incurred for services with Therapist. Therapist only accepts self-pay and does not accept any insurance for services. Therapist is not a direct provider with any insurance company and has opted out of the Medicare system. Therapist will, however, provide client(s) with a statement for services rendered (e.g. superbill), upon client's advanced request and completion of a release of information. I hereby authorize the release of medical information necessary for Therapist to provide me with a statement for services rendered. I understand that I am solely responsible for verifying and understanding the limits of my insurance coverage and seeking reimbursement for fees paid to Therapist for services. I understand that the amount of reimbursement, co-payments, and/or deductible depends on the requirements of my specific insurance plan. I understand that insurance plans generally limit coverage to certain diagnosable mental conditions.

Although Therapist is happy to support clients with their efforts to seek insurance reimbursement, **I understand that I, the client, am personally responsible for the payment of any/all services with Therapist per the terms stated above in this agreement, regardless of whether/when insurance reimburses me or not.**

EMERGENCIES: Non-urgent phone calls are returned during Therapist's normal workdays, generally within 24 hours. If you have an urgent need to speak with Therapist, please indicate that fact in your message and follow any instructions that are provided by Therapist's voicemail. In the event of a medical or psychiatric emergency or an emergency involving a threat to my safety or the safety of others, I agree to call 911 to request emergency assistance or have someone take me to the nearest emergency room. When Therapist is out of town, I understand that I will be advised and given the name of an on-call therapist.

CONFIDENTIALITY: I understand that discussions between Therapist and I are confidential, with the exception of disclosures that are mandated by law and/or requests I make in writing to have all or portions of such content released to a specifically named person(s). I understand that possible exceptions to confidentiality include but are not limited to the following situations: child abuse; dependent and/or elder abuse; certain legally defined situations involving threats of self-harm or harm to another where Therapist has a duty to disclose, or where, in Therapist's judgment, it is necessary to warn or disclose; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; fee disputes between Therapist and the client; a negligence suit brought by the client against Therapist; or the filing of a complaint with the licensing or certifying board. In the case of danger to others, Therapist is required by law to notify the police and inform any intended victim(s). In the case of self-harm, Therapist is ethically bound to inform the nearest relative, significant other, or to otherwise enlist methods to prevent self-harm or suicide. In instances of child abuse, elder abuse, or dependent abuse, Therapist must notify the proper authorities. Should an agent of the federal government request a copy of your records under the Patriot Act (Section 215), Therapist must respond without your knowledge. In couple and family

therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Therapist will use her clinical judgment when revealing such information. Therapist will not release records to any outside party unless authorized to do so by all adult family members who were part of the treatment. Therapist will neither voluntarily participate in any litigation or custody dispute between you and another individual or entity, nor generally provide records or testimony unless compelled to do so by a Court. I understand that should Therapist see me outside of the therapy office, Therapist will not acknowledge me, in order to safeguard my right to privacy and confidentiality. By signing this form below, I am giving consent to the undersigned Therapist to share confidential information with all persons mandated by law, with an agency that may have referred me, with an insurance carrier responsible for providing me with mental health care services and payment for those services, and I am also releasing and holding harmless the undersigned Therapist from any resulting departure from my right to confidentiality.

DUTY TO WARN/DUTY TO PROTECT: If Therapist believes that I (or my child, if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to Therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name/Relationship/Location _____ Number _____

Name/Relationship/Location _____ Number _____

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another therapist and for that therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

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COMMUNICATION: Therapist may need to communicate with me or leave messages by telephone or other means. I hereby provide Therapist consent to contact me by telephone, voice message, text, and/or email, unless I've indicated otherwise here: _____

I understand that, to protect my confidentiality, Therapist will not discuss clinical issues with me via email or text message, considering email/text correspondence will not be specifically encrypted or otherwise protected for security purposes. I understand that email and text will solely be used for the purpose of setting and confirming appointments and are not a permissible means to request assistance during an emergency. While phone sessions are available for additional support when warranted and reasonably necessary, I understand anything beyond a 10 minute phone conversation will be charged at Therapist's regular hourly rate.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read carefully, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time and/or discuss referrals or treatment alternatives with Therapist.

_____ _____
Signature – Client/Parent/Spouse 1 Date

_____ _____
Signature – Client/Parent/Spouse 2 Date

_____ _____
Witness Date