Informed Consent

This Informed Consent Form is intended to provide sufficient information for you to make informed choices about entering and continuing therapeutic treatment. The specifics of the treatment goals and the steps to achieve these goals will be discussed at the first appointment. Your participation and understanding of the treatment goals is essential for the best benefit of therapy.

YOUR THERAPIST

Your therapist, Lisa Marks, is a Licensed Marriage and Family Therapist, #107491. At an appropriate time, your therapist will discuss his/her professional background with you and provide you with information regarding his/her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience and professional orientation.

INFORMATION ABOUT THIS PRACTICE

The name of this practice is Mindful Guides, A Marriage & Family Therapy Corporation. This is a Marriage & Family Therapy Professional corporation and operated by individual therapist, Nicole Kahn, #42737.

WHAT TO EXPECT – BENEFITS AND RISKS

There are benefits and risks in seeking individual, marital or family therapy. Some of the potential benefits of therapy include developing your ability to handle or cope with your relationships and providing you with greater insight into your personal goals and values. In working to achieve these benefits, however, you may address issues or make changes that you may experience as distressing. These risks of therapy include, but are not limited to: feelings or circumstances becoming worse before they get better; changes in your emotional state, such as feelings of depression or anxiety; the possibility of hallucinations or dissociations; changes in perception or behavior; and changes in occupational, social, or personal relationships.

RIGHTS OF CONFIDENTIALITY

Your therapist pledges to uphold privacy and confidentiality concerning your treatment process and records as outlined by California Statute. Lisa will do everything within her power to protect the physical records of treatment and the information contained therein, including safeguarding their use, transportation and storage. It is understood that all information between client and therapist is held strictly confidential, and the therapist will not release any information about therapy unless permitted by law or:

1. It is agreed upon in writing and complies with State Laws.
2. The client presents an imminent danger to self.
3. The client presents an imminent danger to others.
4. Child/Elder abuse/neglect is suspected.
5. As necessary for continuity of care.
6. If a judge determines that our discussions are not confidential, a judge may request specific information.
7. As requested by a court appointed attorney for a child involved in court proceedings.

It is understood that in cases #2, #3, and #4, the therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. If I participate in group counseling, I agree not to discuss any details of the group outside of the counseling sessions.

ELECTRONIC COMMUNICATION DISCLOSURE

Sensitive, clinical information is to be discussed over the phone or in-person as deemed appropriate by the therapist. For appropriate e-mail or text communication therapist will do her best respond to your e-mail or text within 24 hours. Potential risks of using electronic communication may include, but are not limited to; inadvertent sending of an e-mail or text containing confidential information to the wrong recipient, theft or loss of the computer, laptop or mobile device storing confidential information, and interception by an unauthorized third party through an unsecured network. E-mail messages may contain viruses or other defects and it is your responsibility to ensure that it is virus-free. In addition, e-mail or text communication may become part of the clinical record. You may be charged for time the therapist spends reading and responding e-mail or text messages.

PATIENT CONSENT TO RELEASE OF INFORMATION

I consent to information release about my case (or my child's case) with the referral source. Where applicable, I further consent to the release of information to my health plan for claims, certification/case management/quality improvement and other health plan purposes.

GENERAL CONSENT FOR TREATMENT

I further authorize and request that my therapist carry out treatment that now or during the course of my care as a client are advisable. I understand that the purpose of these treatment practices will be explained to me upon my request and are subject to my agreement.

GENERAL CONSENT FOR TREATMENT(If client is a child or dependent)

On the patient's behalf, I (the legal Guardian or Legal Representative) legally authorize Lisa Marks to deliver mental health care services to the client. I also understand that all policies in this statement apply to the client I represent. **I acknowledge that my child's records are considered confidential except in the above stated exceptions.**

HELP FOR EMERGENCIES

In the case of an emergency, please call 911 or the crisis line at (888) 724-7240. You may attempt to contact Lisa for emergency assistance and she will do her best to return your call promptly, however she cannot guarantee to see you as soon as you need. You also may attempt to contact Lisa's colleague, Nicole Kahn, #42737 at (858) 442-5548, however she cannot guarantee to see you as soon as you need.

SESSION FEES

The fee for a 50-minute individual therapy session is $125, the fee for a couple's session is $150, payable to Mindful Guides. Therapeutic services delivered over the phone are subject to the same hourly rate as regular sessions and will be billed on a pro-rated basis. Fees are re-evaluated and subject to change every six months. Lisa Marks is determined to provide psychotherapy to those for whom these fees are out of reach. Please discuss any financial concerns you may have with Lisa during the initial consultation.

PAYMENT POLICY

Payment in full is expected at the time of service, unless alternate arrangements are mutually agreed upon. Payment is accepted in the form of cash or check only. When making payment by check, please have your check written before the start of the session, whenever possible. All checks returned for non-sufficient funds (NSF) are subject to a $20 returned check fee. You are responsible for making any payments due in a timely manner. If you anticipate difficulty in paying your balance, please discuss the situation with Lisa Marks to work out a repayment schedule that will not cause undue hardship for either party. Your account will be considered delinquent if a balance remains after two months from the date the fee is assessed. If your balance remains delinquent for more than four months and you have not attempted to make satisfactory arrangements with your therapist, the account will be considered defaulted. It may be forwarded to a collection agency and you will be responsible for all court costs, attorney fees, interest, and related damages or expenses associated with pursuing payment of the balance.

CANCELLATION POLICY

The time for which your appointments are scheduled has been reserved for you. You are required to give notice of cancellation at least 1 full business day prior to a scheduled appointment. If you do not give 1 full business-day notice or fail to show for a scheduled appointment without prior notification, you will be charged the full session fee. Exceptions can be made in the event of an emergency *only*; however, you are asked to call as soon as possible to inform your therapist of the circumstances. Your therapist will provide an appointment card so you can verify the times and dates, unless the appointment is made over the phone or you decline to receive one. Please understand that your insurance company will not pay for missed or cancelled sessions.

ACCEPTANCE OF POLICIES

Your signature represents a statement that you have read and understood the information above and as outlined by me, Lisa Marks, have received a copy of this Informed Consent form, have been made aware of your rights and the privacy practices of this office, agree to comply with fees and policies and consent to the therapy process as described above. You have the right to withdraw your consent for treatment at any time.

_____ _____ _____

Client Signature Date Client Signature Date

_____ _____

Parent/Guardian Signature (if client is under 18) Date