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Informed Consent for Treatment

Client Name: _____ DOB: _____ Date: _____

Welcome to my counseling and psychotherapy practice. I have had the privilege of working with people of all ages and many diverse backgrounds. I have practiced social work in many settings. These work experiences have helped me meet and get to know many different people in many unique circumstances. I appreciate the opportunity to work with you.

Paying for Therapy: At this time, your session fee is $____ per 50 minute counseling session. You are personally responsible for your session fee. Payment is due at the outset of the session when services are rendered. You may pay by credit card, cash or check. There is a fee for a returned check.

My counseling rates increase on a yearly basis and I will give you at least one month's notice of a rate change. Due to my small practice, I have limited ability to reduce my fee, but I will do so for current patients experiencing financial hardship. Please discuss finances if they become a concern. If I cannot accommodate your need, I will provide referrals to lower cost counseling clinics. I will terminate services due to non-payment of fees and refer you to other resources in the community. Upon your request, I can provide super bill at the end of each month, which you can submit to your insurance carrier for possible reimbursement.

When my time is used on your behalf at your request (e.g. extended telephone conversations, writing letters, consultations with other professionals involved in your care, reading records, attending meetings), you will be charged at my hourly rate (pro-rated).

If you cannot keep your scheduled appointment, you must give 24 hours notice of your cancellation (email or voicemail is okay) or you will be responsible for your session fee. You may terminate services at anytime, but you will be billed for any outstanding account balance.

I understand my session fee, the cancellation policy, and I agree to pay the assigned fees. Initial _____

Confidentiality : Information provided during counseling will be kept strictly confidential and will not be shared with any person or agency without your written permission, except in the following situations:

(a) if you threaten to harm yourself and we are not able to resolve the issue within treatment, I may seek hospitalization on your behalf, or contact your emergency contact, friends or family to assist in keeping you safe.
(b) if you threaten to commit an act which would cause bodily harm to another person, I am required to notify the potential victim, contact the police or seek hospitalization on your behalf.
(c) if I suspect abuse or neglect of a child/minor, dependent adult or an elderly person, I am required to file a report with the appropriate California agency (Department of Children & Family Services, Adult Protective Services, Police). This is includes reporting if you have disclosed the sexual exploitation of a child by streaming, accessing or downloading child pornography.

(d) if you are gravely disabled, I may seek hospitalization on your behalf.
(e) if a court of law issues a legitimate court order.
(f) if I have to respond to any legal action taken by you against me.

In these situations, I may be required by law to provide information obtained during counseling to other persons or agencies without your permission and perhaps without your knowledge.
Otherwise, if you want your records be released or want me to contact another person or agency, I will require your permission in writing. I will need your permission in writing if you want me to seek third-party payment for your therapy services. If you wish to view or access your records, I will need your request in writing.

You are entitled to a copy of your medical record, unless in my professional opinion, I believe the release of records would be detrimental or cause serious harm to your welfare and/or the release of records would negatively impact the therapeutic relationship between us. Alternatively, I can create a summary of your records. Due to the inclusion of professional language, your records may be easily misinterpreted or misunderstood. If you do view or access your records, I recommend we review them together in session.

In the event of my incapacitation, disability or death, I have authorized Saskia Stockbroekx-Pinto, LMFT, to have access to my client files so she can notify you that I am unavailable, make appropriate referrals and assist you if you need to access your records. As a licensed therapist, she is bound by confidentiality as well.

I use electronic medical records.

Optional: I, _____, authorize Melissa Pirwani, LCSW to provide verbal notification to me in person or by telephone in order to expedite notification in the event of a breach of my protected health information (PHI). **Initial** _____

Confidentiality of Minors: If you are under 18 years of age, your parent(s) or guardians may have the legal right to obtain information about your treatment and/or examine your treatment records, particularly if they are consenting and paying for your treatment. However, you will often benefit more from therapy if your parent(s) refrain from accessing this right. It is helpful for your parent(s) to understand what you are working on in therapy and the impact it is having on you, so they can make good decisions about your care. Periodically, with your involvement and/or consent, I will offer general information related to your progress on treatment goals, or ways your parent(s) can support the work we are doing in therapy. If you are in a high-risk situation that compromises your safety or well being, and I have concerns for your welfare, I will notify your parent(s) so they can take action to protect you. I will include you in this process whenever possible. In session we will work on how/when these disclosures are made, and the therapeutic consequences of these disclosures.

Treatment of Minors: I generally require the consent of both parents prior to providing any services to a minor child, regardless of marital status or responsibility for payment. If any question exists regarding the right of a parent to consent to treatment, I will require a copy of supporting legal documentation, such as the most recent custody order. My role is to help a minor reach their treatment goals, in consultation with the parents.

I am not in a position to make any recommendations verbally or in writing regarding any matter regarding custody. I will not voluntarily participate in any custody dispute. I can refer you to professionals who conduct evaluations or make such recommendations.

Consultation: I regularly consult with other licensed mental health professionals regarding ethical, legal or clinical issues in treatment. However, your identifying information is never mentioned. Confidentially is maintained.

Process of Therapy: Risks & Benefits: Prior to meeting, I have you complete a background information form through a secure patient portal. In the early part of our work, we will review your background, your current symptoms/stressors and discuss your expectations of therapy. We will collaboratively set goals about what to discuss and work toward.

There are risks and benefits to therapy. Your symptoms may increase and you may talk about experiences that are difficult or painful. Further, you may decide to make changes in your life based on the work you do in therapy, and sometimes those changes can be painful and difficult. You may benefit from counseling by experiencing a decrease in distress and symptoms, resolving issues and conflicts that have troubled you, and making changes that are meaningful to you. Change may not happen immediately; in reality, change can be a lengthy and sometimes frustrating process. Together, we will assess risks and benefits throughout your counseling experience.

Litigation: I will not voluntarily participate in any litigation or custody dispute involving a client. 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 a legal matter involving you, you agree 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 an hourly rate of $500.

Disclosures, Limitations and Emergencies: I am a Licensed Clinical Social Worker. You may check my licensure status online at the California Board of Behavioral Sciences. Please note that I am a sole proprietor. Although I share office space, no one in this building, or elsewhere, is part of my private practice.

I am not a physician. I do not prescribe medication. I recommend that you have regular medical exams to rule out or treat medical conditions that can impact your health and mood. I recommend you work with a physician or psychiatrist if you have been diagnosed with a mental health condition. If during the therapy process I do not believe I can be helpful to you, I will discuss this with you, and if appropriate, terminate therapy and refer you to another therapist.

I do not provide emergency services. If you have a mental health emergency or are in crisis, call 911, visit the nearest emergency room, or call the Santa Clara County Suicide and Crisis Line at (855) 278-4204.

Notice to Patients: The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of clinical social workers. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Termination: You may end services at any time. If possible, please discuss your plans for termination in session so that we can therapeutically plan for the end of services and discuss additional community resources. You will be asked to complete an evaluation of your counseling experience.

I may terminate services and refer you elsewhere if I close my practice, if you fail to pay your session fee/balance, if conflicts of interest emerge and we cannot address them in treatment, if you fail to participate in treatment, or if your needs are outside the scope of my practice. If you commit violence to, verbally or physically threaten or harass me, the office, or my family, I reserve the right to terminate your treatment unilaterally and immediately. If you do not show up and/or are out of contact for more than three weeks, I will close your file. You can contact me if you are interested in reestablishing counseling services.

I have read and understood the four-page informed consent form. I consent to assessment, treatment and keeping of records by Melissa Pirwani, LCSW for myself or my minor child. I agree to pay my assigned fee.

_____	_____	_____
Client Name	Client Signature, if over 12	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date
Melissa Pirwani, LCSW	_____	_____
	Signature	Date