Informed Consent for Psychotherapy or Psychotherapeutic Consultation

Welcome. I am a Doctor of Psychology, a Licensed Clinical Social Worker and a Diplomate of the American Psychotherapy Association. This information, like all information that you share with me, is private and confidential.

Clients Rights: Your decision to undergo psychotherapy is strictly voluntary and you are free to discontinue psychotherapy at any time.

Professional Fees: The full payment for each session is your responsibility to take care of at the time of service. I will have you complete a credit card authorization form when I meet with you to keep a credit card on file. If you prefer to pay by check I will still need to keep a credit card on file. The card will be used for charging any visit not paid by cash or check within 36 hours of receiving services, and if you choose to pay by credit card weekly.

Conditions of Care and Cancellation Policy: My standard psychotherapy session is 50 minutes per week. Sessions reserved weekly are considered medical appointments and must be consistent. There are no exceptions to my cancellation policy. Phone sessions do not replace face to face sessions unless we have pre-arranged for it. Phone sessions are billed at full fee per 50 minutes. As a courtesy, 24 hour cancellation is requested on all sessions.

Responsible attendance weekly with regularly reserved weekly scheduled appointments is an important factor in the treatment. Occasionally, of course, it is necessary to miss or reschedule a session. Once we set a regular time for our sessions, I have what is called a "no cancellation" policy. This means that you are responsible for all regularly scheduled sessions. This session is held for you and not released to another patient until it is agreed upon that you will no longer be in psychotherapy or you schedule as needed. I am happy to try to reschedule when necessary in the same week if you cancel and session availability allows but there is not a guarantee that I will be able to reschedule in that week. Please be reminded you would still be responsible for your original session time with the "no cancellation" policy. As a courtesy, you may miss up to four sessions without penalty in a full treatment year in addition to my vacations. If you are here twice a week you may miss up to 6 sessions without penalty in a full treatment year. If you do not need to miss the allowed sessions then you are responsible for all sessions scheduled and, or attended.

Another option if you do not want to schedule a reserved regular weekly time is to schedule as needed. This option will depend on Dr. Richman's scheduling availability.

Most insurance companies do not reimburse for missed sessions. Should your account become delinquent by a three month period, and you do not comply with a mutually agreed upon schedule of payment, your account may be turned over to a collection agency. The prevailing party in any collection efforts, including arbitration or litigation, shall be entitled to recover a reasonable sum for attorneys' fees. If you would like to submit a bill to your insurance company for reimbursement, please let me know and I will provide you with an invoice at the end of each

month. I do not work directly with insurance companies, but if your policy provides for some reimbursement for work with out-of-network providers, I will be happy to provide you with the required documentation. As was indicated in the section, Health Insurance & Confidentiality of Records, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues / conditions / problems, which are the focus of psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.

Termination of Treatment: By law, I have no obligation to continue to provide treatment. I can terminate treatment if payment is not timely, or if some problem emerges that is not within my scope of competence, or for any other reason. If at any time I am unable to provide you with appropriate care within my scope of services, I will offer you three referrals for follow-up. I am governed by various regulations and by the code of ethics of my profession. I am required to inform you of certain aspects of your psychotherapy.

Contact: I make every attempt to answer voicemail and return the call on the same day. If you are unable to reach me and feel that you cannot await my return call, please contact your psychiatrist, or call 911 if you feel that it is an emergency.

Confliction Resolution: By signing below, you and I agree to address any grievances we may have with each other (e.g., billing or claims of malpractice) directly. 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 of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney, nor anyone else acting on your behalf will call on me, Dr. Richman, to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. If we cannot settle the matter between us, then we agree to seek the assistance of a neutral third party (upon whom or which we jointly agree) to assist us by way of non-binding mediation. If an agreement still is not reached, we agree that any dispute, claim or controversy arising out of or relating to this agreement, or the breach, termination, enforcement, interpretation or validity of this agreement, including the determination of the scope or applicability of this section will be determined by arbitration in Los Angeles, California, before one arbitrator. You are agreeing to have any issue of medical or psychological malpractice decided by neutral arbitration and you agree to give up the use of a jury/court trial. A judgment based on the arbitrator's award may be entered in any court having jurisdiction.

Limits of Confidentiality: In general, law protects the privacy of all communications between a client and a mental health professional. With some limited exceptions, I can only release information about our work together with your written /verbal permission. The exceptions include child custody, a judge orders my testimony, child, or elder abuse, if I believe that a person is threatening serious bodily harm to another or to themselves, if you are required to sign a release of confidential information by your medical insurance, and if you are required to

sign a release for psychotherapy records if you are involved in litigation or other matters with private or public agencies. Also, couples being seen in couple, family and group work are obligated legally to respect the confidentiality of others. The therapist will exercise discretion (but cannot promise absolute confidentiality) when disclosing private information to other participants in your treatment process. The therapist cannot keep secrets from others involved in your treatment. I may at times speak with my professional colleagues about our work without asking permission, but your identity will be disguised. Clients under 18 do not have full confidentiality from their parents. It is also important to be aware of other potential limits to confidentiality that include the following: all records as well as notes on sessions and phone calls can be subject to court subpoena under certain extreme circumstances. Most records are stored in locked files but some are stored in secured electronic devices. Cell phones, fax and email are used on some occasions. All electronic communications can compromise your confidentiality.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health PPO in order to process the claims. If you instruct me, I will communicate the minimum necessary information to the carrier. 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 eligible to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies' computers and soon will also be reported to the, congress-approved, National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access. You signature also verifies that you understand that services provided may not be covered by your policy and that you are financially responsible for these services even if deemed unnecessary or not payable by your carrier when you request out of network reimbursement.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder, abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled (for more details see also Notice of Privacy Practices form).

Privileged Communication: The above refers to a client's right not to have confidential information revealed in court or other legal proceedings. Privilege is waived when: 1) A client has consented specifically and in writing to disclose information; 2) When the client has disclosed a significant part of the information to a third party; 3) Or any of the following (Sections 910 through 1027 of the California Evidence Code) a) When the client is a minor under 18 years of age, the parent or guardian is holder of the privilege; b) When the client is in a criminal proceeding based on an insanity plea, or when a client introduces own mental health as issue in legal proceedings; c) When client alleges a breach of duty against the therapist; d) When client seeks help from the therapist to commit or plan a crime; e) When the client is dangerous

to self or others; or f) When client is under 18 years of age, is the victim of a crime and disclosing the information is in the best interest of the client. I may occasionally find it helpful to consult other professionals about a case. During the consultation I will not give any identifying information about you to keep your identity anonymous. In addition, the consultant is legally bound to keep the information confidential.

E-mails, Cell Phones, Computers, and Faxes: It is very important to be aware that computers and email and cell phone communication can be relatively easy to access by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Additionally, my emails are not encrypted, but can be upon request and faxes can be sent erroneously to the wrong address. My computer is equipped with a password and I back up all confidential information from my computer to a hard drive on a regular basis and my server is HIPAA protected. Please notify me if you decide to avoid or limit, in any way, the use of any or all communication devices, such as email, cell phone or faxes. If you communicate confidential or highly private information via email, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and I will honor your desire to communicate on such matters via email. Please, be aware that emails are part of the medical records, and do not use email for emergencies. Due to computer or network problems emails may not be deliverable. By signing below you authorize the use of email for communication with informed consent, and accept that HIPAA related privacy issues cannot be guaranteed.

I hereby acknowledge that I received a copy of this mental health/psychotherapy practice's Informed Consent. There is a copy that is present in the waiting room of the office. A copy is always present with Dr. Richman and any amended copy will be available to me.

Print Name: _____ Signature: _____

Date: _____ Home: _____ Work: _____ Mobile: _____

Address: _____

City/Zip: _____

Email: _____

Date of Birth: _____ Social Security #: _____

Emergency Contact and Phone #: _____

Relationship to patient: _____