Consent for Treatment

This agreement is intended to provide_____ with important information regarding the practices, policies, and procedures of Suzanne G. Gorter, MFT, and to clarify the terms of the professional therapeutic relationship between Therapist and Client. Do not hesitate to discuss any questions or concerns that you have with the content of this agreement prior to signing.

Risks and Benefits: Psychotherapy is a process in which we discuss many issues, events, experiences, and memories for the purpose of creating positive change so that you can achieve healing and experience life in positive ways. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. While there is no guarantee of what you will experience, the goal and hope is that the client and therapist working together will achieve the goals and benefits that are desired.

Confidentiality: Confidentiality is essential to the therapeutic process. The privacy of all communication between a client and therapist is protected by law. I cannot tell anyone else that you are a client, what is said in therapy, or release any information about our work together without a signed release of information from you. There are some important exceptions to confidentiality. As a mandated reporter I am legally obligated to report the following situations.

1. Child Abuse-If I have reason to suspect that a child is being abused or neglected, I must make a report to the appropriate agency.
2. Elder and Dependent Adult Abuse-If I have reason to suspect that an adult over 65 or a dependent adult aged 18-64 is being abused, I am required to report to the appropriate agency.
3. Intent to Harm –If you report your intent to harm another individual, I am required to take protective actions which may include informing law enforcement and the intended victim.
4. Suicidality-I am legally allowed to break confidentiality in order to take protective measures if I believe you are in danger of harming yourself. These may include contacting family members or others who can provide protection or to seek hospitalization for you.
5. Insurance Providers-I will provide third-party payers requested information regarding services. These include, but are not limited to: types of service, dates/times of service, diagnosis, treatment plan, and progress of therapy.

*I have read and understand these limits to confidentiality*_____.

Client's Initials

Therapist-Client Privilege: Information disclosed by you, the client, as well as my records are subject to the Therapist-Client privilege. This privilege is established by law to recognize the special relationship between a client and therapist, similar to doctor-patient privilege. Typically the client is the holder of the privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the Therapist-Client privilege on your behalf until instructed, in writing, to do otherwise by you or by your representative. Please be aware that you may be waiving the Therapist-Client privilege if you make your mental or emotional state an issue in a legal proceeding. If you have questions or concerns regarding the Therapist-Client privilege, please address them with your attorney.

Record Keeping: I am required by law to keep treatment records. These records are the sole property of the therapist. If you should request a copy of your records, the request must be made in writing. I reserve the right, under California law, to provide a summary in lieu of actual records. I will keep records for ten years following the end of therapy and then they will be destroyed in a manner that preserves client confidentiality.

Fees: My usual and customary fee for services is 120.00 per 50 minute session. I reserve the right to adjust this fee periodically and will notify you in advance if this fee is adjusted. This fee may also be adjusted by contract with insurance, managed care organizations, other third party payers, or by agreement with the therapist.

The agreed upon fee for your sessions is $_____. Payment is due at the beginning of each session, unless we have made other arrangements and can be made by cash, check, or credit card.

From time to time you and I may have telephone conversations for purposes other than scheduling and I may have telephone conversations with third parties at your request and with prior written authorization. You are responsible for payment of phone calls longer than 15 minutes, prorated on our agreed upon fee.

Insurance: I am a contracted provider with a limited number of providers. If your policy covers services, signing this consent form also serves as permission for me to share the necessary information with the insurance company to bill for services. Should you choose to use an insurance for which I am not a contracted provider, I will provide you with a statement which you can submit to your insurance company to seek reimbursement of fees already paid. My services would be considered "out of network" provider services. It is your responsibility to verify and understand the limits of your coverage, as well as your co-payments and deductibles.

Cancellation Policy: Regular attendance at your therapy appointment is part of your commitment to the psychotherapy process. Sessions are 50 minutes long and typically scheduled on a consistent day and time, which is then set aside for you as my commitment to that process. A minimum of 24 hours notice is required for rescheduling or cancellation of an appointment, with the exception of valid emergencies or illness. Payment of our agreed upon fee is required for appointments missed without notification.

Telephone and Emergency Procedures: You can reach me by calling 805-235-5407. I check my voicemail throughout the day and will make every effort to contact you within 24 hours or by the next business day. I will arrange for telephone coverage by a qualified therapist if I am out of town. I am unable to provide 24-hour crisis service. In the event that you are feeling unsafe or you require

immediate medical or psychological assistance, call 911, Mental Health at 781-4700, Hotline at 1-800-783-6070, or go to the nearest Emergency room.

Termination: I reserve the right to terminate therapy for reasons that include, but are not limited to: failure to follow treatment recommendations, failure to participate in therapy, non or sporadic attendance, if you have missed 3 consecutive appointments without notification, conflict of interest, or if your issues are out of my scope of competence or practice. If either you or I decide to terminate therapy, I will generally recommend that we have at least one, possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and to reflect on the work that has been done. I will also attempt a smooth transition to another therapist by offering referrals to other therapists in the area.

Acknowledgement: I have read this statement, asked any questions that I have regarding its content, and understand it. I agree to abide by the terms and conditions of this agreement and consent to treatment by Suzanne G. Gorter, MFT. I agree to hold Suzanne G. Gorter, MFT, free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that my result from such treatment.

_____

Patient Name (please print)

_____ _____

Patient Signature (or authorized representative) *Date*