Donna S Scott Therapy

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INFORMED CONSENT FOR TREATMENT

Welcome to *Donna Scott Therapy*. This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions you may have regarding its contents.

FEES: The fee for a 50-minute psychotherapy session is $175.00. Fee reduction may be considered in some cases. Payment is to be made in full at the beginning of each session in the form of cash, credit card or personal check unless an outside source is covering your payment.

CANCELLATIONS: A minimum of 24 hours' notice is required to cancel or change a session. If you cancel within 24 hours, you will be charged for the missed session. Please include your credit card number and expiration so we may charge your card if you do not cancel within 24 hours.
Card #_________________________________ Exp_______
If you are late, out of respect to the next client, we will end on time and not run over into the subsequent person's session.

INSURANCE: *Donna Scott Therapy* does not bill insurance companies. While I will supply a suitable receipt, it is the client's responsibility to submit claim forms for reimbursement to his/her insurance company. Please be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. It is your responsibility to understand and verify the limits of your insurance coverage. If your insurance denies payment of any service, payment of service is your responsibility. If for some reason you are unable to pay for your therapy, inform me immediately. I will help you consider options which may be available to you.

PHONE SESSIONS: Telephone consultations between office visits are welcome. However, I will attempt to keep those contacts brief due to my belief that important issues are best addressed within regularly scheduled sessions. Phone sessions are charged at the same rate as a psychotherapy session.

RETURNED CHECKS: *Donna Scott Therapy* will require a $25.00 fee (in addition to the original amount) for any returned checks.

CONFIDENTIALITY: All communications between you and I will be held in strict confidence unless you provide written permission to release information concerning your treatment. If you participate in couples or family therapy, I will not disclose confidential information about your treatment unless all who participated in the treatment with you provide their written authorization to release. However, it is important you know that I utilize a "no-secrets" policy when conducting family or marital/couples therapy. Please feel free to ask me about this policy and how it may apply to you.
There are exceptions to confidentiality. Therapists are required by law to report the following:

1. Instances of suspected child or elder abuse.
2. Instances when a client presents serious danger of physical violence to another person.
3. Instances when a client is dangerous to him/herself.
4. Instances when a therapist is required by federal law to release confidential information per the Patriot Act 2001.
5. 11165.1 Penal Code (AB 1775) A person who depicts a child in, or who knowingly develops, duplicates, prints, downloads, streams, accesses through any electronic or digital media, or

exchanges, a film, photograph, videotape, video recording, negative, or slide in which a child is engaged in an act of obscene sexual conduct.

RELEASE OF INFORMATION: A Release of Information Form signed by you is required before I will send records to or request records from other health care providers. The exception is in the case of a delinquent account. Financial information can be forwarded to a collection agency, but I hope that would never be necessary.

ABOUT THE THERAPY PROCESS: It is my intention to provide services that will assist you in reaching your goals. Based upon the information you provide to me and the specifics of your situation, I will provide recommendations to you regarding treatment. The results can be concrete observable change, such as eliminating unwanted habits or symptoms, or a more abstract change such as increased life/relationship satisfaction. Sometimes, confronting your challenges may initially exacerbate the symptoms. Over time however, with continued work and progress you should experience improvement. I believe therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Due to the varying nature and severity of problems and the individuality of each client, I am unable to predict the length of your therapy or guarantee a specific outcome or result.

TERMINATION OF THERAPY: The length of your treatment and the timing of the eventual termination of your treatment depend upon the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan and goals or terminating your therapy.

CONSENT: Your signature indicates that you have read this agreement for services and understand its contents. Please ask me to address any questions or concerns you have about this information before signing.

1) ___________________________ ___________________________ ________________
Client Name ***Client Signature*** ***Date***

2) ___________________________ ____________________________ ________________
Client Name ***Client Signature*** ***Date***