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CONSENT TO TREATMENT AND CONFIDENTIALITY

CONSENT TO TREATMENT

Psychotherapy may involve change, or the possibility of change, which may feel threatening and cause anxiety not only to you but also to those people close to you. The prospect of giving up old habits, no matter how destructive or painful, can often make you feel quite vulnerable. At the same time, discovering tools and techniques that are used to improve the quality of your life and your relationships can be very helpful. Most people find the benefits of therapy outweigh any risks. In fact, sometimes there can be more risks associated with *not* participating in therapy.

My Credentials: I am a **licensed clinical psychologist** and an **independent private practitioner.** I provide individual, couples and family therapy to adults, adolescents and children.

Session Duration: Unless otherwise agreed, the session is **45-50 minutes** in length. Weekly appointments are the usual pattern when beginning psychotherapy. Other arrangements may be made depending on your individual circumstances and clinical needs.

Fees: My fees are $150 for the initial evaluation, $130 for individual psychotherapy, and $150 for couples or family therapy. The fee for forensic services (depositions, court appearances, etc.) is $300/hour, including travel time, with a half-day minimum. ***Fees are paid at the time of the appointment.***

Insurance Reimbursement: Your health insurance policy may provide some coverage for mental health treatment. I can provide you and/or your insurance company with a monthly statement; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

Missed or Canceled Appointments: ***No-show or canceled appointments may incur the full charge of the session unless a twenty-four hour notice is given*.** Exceptions are unforeseen emergencies that could not have been anticipated such as personal or family illness and automobile difficulties or other accidents. Please call and let me know as soon as possible if you will not be able to come to your appointment. You may leave

a time stamped voice mail messages at **967-0778, extension 15**, which is available **24 hours a day**, 7 days a week.

General Availability and Telephone Calls: I am available in the office for appointments and telephone calls on **Tuesday, Wednesday, and Thursday from 9:00AM until about 2:00PM**. During evenings and other days of the week, (Friday, Saturday, Sunday and Monday), a message can be left on my voice mail at any time. **If it is urgent you reach me during these hours, leave your message and press "#71" to mark it as urgent.** I will return your call as soon as I am able. Please remember to leave your telephone number(s), including cell #s. ***If your call is not returned within two days, please call again. Errors can occur in telephone numbers or voice mail clarity*.**

Emergencies: ***If you are dealing with an imminent or life-threatening emergency please phone 911 immediately*. If you are experiencing a psychiatric emergency, please call Sutter Center for Psychiatry at (800) 801-3077.**

Professional Records: The laws and standards of my profession require that I keep information about you in your Clinical Record. Except in unusual circumstances where I believe that access is reasonably likely to cause substantial harm, you may request a copy of your Clinical Record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents.

Treatment of Minors: In most cases, when the patient is a minor, the law allows parents to examine their child's treatment records. However, because privacy is crucial to successful progress for many children and adolescents, it is usually my policy to request an agreement between patient and their parents about access to information. This agreement provides that during treatment, I will give only general information about progress and the patient's attendance at scheduled sessions. If a patient discloses something which affects their safety, I will either assist the patient in discussing this with their parents or notify their parents of my concerns. In the rare case where disclosure of this information to the parent would put the patient at risk, I will notify the appropriate agencies to ensure the patient's safety.

Termination: As the patient, you have the right to terminate treatment at any time. As the therapist, I can terminate treatment at anytime and facilitate a referral. If I determine you are not sufficiently benefiting from treatment, it is my ethical duty to refer you to alternative care.

CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you provide written Authorization. But, there are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- I may find it helpful to consult other health and mental health professionals about a case without revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential.

- I also have a contract with a billing service. I have a formal business associate contract with this business, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. I can provide you with the name of this business and/or a blank copy of this contract.

- You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis and sometimes additional clinical information. I will make every effort to release only the minimum information about you that is necessary for the purpose requested. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

- If you are involved in a court proceeding and a request is made for records, I cannot provide any information without your written authorization, a court order, or other legal action compelling me to release the information. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities pursuant to their legal authority, I may be required to provide it for them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If a patient files a worker's compensation claim, I must, upon appropriate request, disclose information relevant to the claimant's condition, to the worker's compensation insurer.

- If a patient's account is seriously past due, I may disclose necessary information to a collection agency.

There are some situations in which I am legally <u>obligated</u> to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I reasonably suspect that a child under 18 has been the victim of child abuse or neglect, the law requires that I file a report with the appropriate governmental agency. I also may make a report if I reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in

any other way. Once such a report is filed, I may be required to provide additional information.

- If I observe or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, the law requires that I report to the appropriate government agency. Once such a report is filed, I may be required to provide additional information.
- If a patient communicates a serious threat of physical violence against an identifiable victim, I must take protective actions, including notifying the potential victim and contacting the police. I may also seek hospitalization of the patient, or contact others who can assist in protecting the victim.

- If I have reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to him or herself, I may be obligated to take protective action, including seeking hospitalization or contacting family members or others who can help provide protection.

If such a situation arises, I will make every effort to fully discuss it with you and I will limit my disclosure to what is necessary.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTOOD THIS AGREEMENT AND THAT YOU VOLUNTARILY AGREE TO PARTICIPATE IN TREATMENT. If the person receiving care is a minor, a parent or legal guardian acknowledges having read and understood this document and voluntarily agrees to the minor's participation in treatment..

SIGN HERE

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Patient's/Guardian's Signature Date

I hereby assign all medical (mental health) benefits to include major medical policy benefits to which I am entitled, and/or government sponsored programs, private insurance companies, and any other health plan to Patricia D. Brunner, Ph.D. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all legally contracted charges whether or not paid by my insurance company. I hereby authorize Patricia D. Brunner, Ph.D. to release all information necessary to ensure payment of benefits. A copy of this agreement is as valid as the original.

SIGN HERE

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Patient's/Guardian's Signature Date

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Printed Name