Deborah L. Farnsworth, Psy.D.

A Professional Corporation
MFT 37450
1151 Dove Street, Suite 278,
Newport Beach, CA. 92660
949-257-7178

Informed Consent for Individual Psychotherapy

The State of California requires that you be informed of all possible contingencies that might arise in the course of short- and long-term therapy. Please check to be sure you have read, understood, and discussed all questions with your therapist. An informed consent has the force of contract, so we cannot proceed until we reach an agreement on all items.

Name_____ Fee_____

Address_____

City_____ Zip Code_____

Email _____ Work Phone _____ Mobile _____

Date of Birth _____

Referred by: _____

Emergency Contact _____

Agreement for Dynamic Psychotherapy

(Please initial each of the following)

_____I have read this informed consent completely and have raised any questions I might have about it with my therapist. I have received full and satisfactory response and agree to the provisions freely and without reservations.

_____I understand that my therapist is responsible for maintaining all professional standards set forth in the ethical principles of his/her professional association as well as the laws of the state of California governing the practice of psychotherapy and that she is liable for infractions of those standards.

_____I understand that I will be fully responsible for any and all legal and/or collection costs arising as a result of my contact with my therapist, including appropriate compensation for his time involved in preparing for and doing court work.

_____I understand that my therapist from time to time makes teaching and research contributions using disguised client material. By consenting to treatment, I am giving consent to this process of professional contribution and the right to use disguised material without financial remuneration.

_____I understand the **48-hour** cancellation policy and that I am responsible for all regularly scheduled consultation sessions *whether or not I am able to attend*. If, for any reason, I am unable to attend a regularly scheduled session, I will try to find an alternate time slot. However, if another time cannot be found, I understand that ***I will be financially responsible for canceled or missed sessions***.

_____If I required a monthly billing statement, I give permission to my therapist to send statements via email.

Arbitration Agreement

I agree to address any grievances I may have directly with my therapist immediately. If we cannot settle the matter between us, then a jointly agreed-upon outside consultation will be sought. If not, an arbitration process will be initiated, which will be considered as a complete resolution and legally binding decision under state law, which [in California] states us follows:

"NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE ONE OF THIS CONTRACT."
Article 1: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by [state] law, and not by lawsuit or resort to court process except as [state] law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." Any arbitration process will be considered as a complete resolution and legally binding decision. The client will be responsible for the costs of this process. In agreeing to treatment, you are consenting to the above identified grievance procedures.

This agreement constitutes the entirety of our professional contract. Any changes must be signed by both parties. I have a right to keep a copy of this contract.

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date

_____ _____
Legal Parent or Guardian Signature Date

Statement of the Therapist:

This document was discussed with the client and questions regarding fees, diagnosis, and treatment plan were discussed. I have assessed the client's mental capacity and found the client capable of giving an informed consent at this time.

Date and Initial of Therapist _____.

The following pages cover office policies and treatment:

Note on Cancellations: Due to the long-term nature of my practice, I must hold you responsible for all regularly scheduled consultation sessions *whether or not you are able to attend*. **I require 48 hours notice for all cancellations**. If you are unable to attend a regularly scheduled session, I will try to find an alternate time slot. However, if another time cannot be found, ***you will be responsible for canceled or missed sessions that fall short of my 48 hour policy.***.

Note on Insurance Reimbursement: I do not take insurance although many PPO and POP insurance plans will reimburse you for a percentage of my fee. I ask that you pay your fee at the beginning of each session unless we agree upon another arrangement. If I agree to send you a monthly bill, I ask that you *pay in full no later than the tenth of each month*. A copy of your bill can be submitted by you with your insurance form directly to your company. Insurance payments will be sent directly to you.

Confidentiality: State law and professional ethics require therapists to maintain confidentiality except for the following situations:

1. If there is suspected child abuse, elder abuse, or dependent adult abuse.
2. "Tarasoff" situations in which serious threat to a reasonably well-identified victim is communicated to the therapist.
3. When threat to injure or kill oneself is communicated to the therapist.
4. If you are required to sign a release of confidential information by your medical insurance.
5. 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. **Think carefully and consult with an attorney before you sign away your rights.** We can discuss some foreseeable possibilities together.
6. Clients 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.
7. I may at times speak with professional colleagues about our work without asking permission, but your identity will be disguised.
8. Clients under 18 do not have full confidentiality from their parents.
9. 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, portable phones, faxes, and e-mails are used on some occasions.
•All electronic communication compromises your confidentiality.

Fees: The fee for service generally covers a 45-minute session and will be agreed upon in the first treatment session. Fees are due at the beginning of each session unless prior arrangement has been made with the therapist. Cost of living increases may occur on an annual basis. Telephone calls may be charged at approximately the same rate as personal consultation plus any telephone company charges. Interest at 12% per annum will be charged on all accounts over 60 days due.

Availability: The therapist is available for regularly scheduled appointment times. Dates of vacations and other exceptions will be given out in advance if possible. Telephone appointment times can be made by calling the office during regular office hours. My regular office hours are 8 AM to 5 PM Monday through Thursday. If you contact me during regular office hours, I will try to respond within 24 hours. If you contact me after hours or on the weekend I will attempt to respond as soon as I am able, however sometimes that may be longer than 24 hours. If you are in a life-threatening emergency, please always call 911 as a first resort.

Emergency number where I can *sometimes* be reached: 949-257-7178.

Emergency service can be obtained at

Hoag Hospital One Hoag Drive Newport Beach CA 92663 949/764-HOAG (4624)	Irvine Regional Hospital and Medical Center 16200 Sand Canyon Avenue Irvine, CA 92618 949-753-2000

Termination of Treatment: The therapist may terminate treatment if payment is not timely, if prescriptions are not filled (such as seeking consultation, refraining from dangerous practices, coming to sessions sober, etc.), or if some problem emerges that is not within the scope of competence of the therapist. The usual minimal termination for an ongoing treatment process is four to ten sessions but a satisfying termination to long-term work may take a number of months.

Clients are urged to consider the risks that major psychological transformation may have on current relationships and the possible need of psychiatric consultation during periods of extreme depression or agitation. Not all people experience improvement from psychotherapy and therapy may be emotionally painful at times. If you would like information on shorter term behavioral and cognitive therapies, I would be happy to provide you with referrals. Patients have the right to refuse or to discontinue services at any time and complaints can be addressed to the following:

Deborah Farnsworth Psy.D. Inc. **1151 Dove Street, Suite 278** **Newport Beach, CA 92660**	**DEPARTMENT OF CONSUMER AFFAIRS** **1625 NORTH MARKET BLVD., SUITE N** **112 SACRAMENTO, CA 95834**