Ken Goodman, LCSW

Anxiety Treatment of the Valley

LCS15866

CONSENT FOR TREATMENT

I welcome you to my office and I want you to know I am committed to helping you end your suffering. Over 40 million Americans suffer with some form of anxiety or OCD and most do not seek treatment. You are taking the first step towards finding the freedom you desire. As a licensed clinical social worker am governed by various laws and by the code of ethics of my profession. I want to make you aware of these laws as well as specific office policies.

This agreement is between Ken Goodman, LCSW and _____ .
(Patient Name)

Benefits of Therapy: Participating in therapy may result in a reduction or elimination of symptoms including physical symptoms of anxiety, stress and depression, negative and unwanted thoughts, greater freedom to participate and enjoy life, increased self-worth, greater ability to function at home and at work, and improved relationships with family and friends. Such benefits usually require substantial effort on the part of the patient, including active participation in the therapeutic process, honesty, openness, and completion of the agreed upon homework between sessions. There is no guarantee that therapy will yield all of the benefits listed above but most patients improve greatly with hard work, patience and persistence.

Limits of Confidentiality: Therapy sessions between a psychotherapist and patient are strictly confidential except under certain legally defined situations involving threats of self-harm or harm to another, and cases of past or present child abuse, elder abuse, or abuse of dependent individuals. In case of danger to others, I am required by law to notify the police and to inform any intended victim(s). In the case of self-harm, I am legally bound to inform the nearest significant other, or to otherwise enlist methods to prevent self-harm or suicide. In instance of child abuse, elder abuse, or dependent abuse, I must notify the proper authorities.

Records and Record Keeping: I take notes during sessions. These notes constitute my clinical and business record, which all therapists are required by law to maintain. Such records are the sole property of the therapist and are kept confidential. Under California law, therapists reserve the right to refuse to produce a copy of the record and may choose to provide a treatment summary in lieu of actual records. At the written request of the patient, a copy of the record may be sent to another treating healthcare provider for the purpose of continuity of care. After seven years, patient records will be destroyed in a manner that preserves client's confidentiality.

Appointments and Cancellation Policy: Sessions are 45 minutes in length. If you need to cancel or reschedule an appointment, please notify me at least 24 hours in advance. This will allow me time to fill the appointment. You will be charged **$60** for no-shows and same day cancellations, including emergencies, unless I fill the appointment with another patient.

Psychotherpist-Client Privilege: Information disclosed by the patient, as well as any records created, are subject to psychotherapist-client privilege. If I receive a subpoena for records, deposition testimony or testimony in a court of law, I will assert psychotherapist-client privilege on your behalf until instructed in writing to do otherwise. You should be aware that you might be waiving this privilege if you make your mental or emotional state an issue in a legal proceeding. Should I be subpoenaed, or ordered by a court of law, to appear as a witness, patient agrees to reimburse therapist at the hourly rate for any time spent in preparation, travel or any other time in which I made myself available.

Fee and Insurance: I do not accept insurance except for Kaiser and PPO insurance. My fee is $160 for a 45 minute session. Full payment is due each session via cash or check. There is no charge for phone calls less than 10 minutes. A 25-minute phone call is billed as half of a session. If you have a PPO, payment is made in full each session. I will bill your insurance company and you may receive reimbursement depending upon your benefit. In rare circumstances insurance companies request records to substantiate further authorization of treatment. By signing this document you are giving permission for me to forward any requested records to insurance company and to bill insurance with a diagnosis code and dates of service.

Telephone, Text and Email Accessibility: I am available 24 hours a day, seven days a week for urgent matters. If I do not return your call within 15 minutes please call again. I will make every effort to call you back asap. If you are having an emergency please call 911. If not an urgent matter, leave a voicemail or text and I will contact you within 24 hours. Keep in mind that email, text and phone calls can be accessed by unauthorized people and your privacy may be compromised. If you communicate personal information via email, cell, fax or text, you have made an informed decision of the risk. By signing this you agree to receive my texts confirming our appointments.

Social Networking: I do not accept friend requests from current or former patients.

HIPPA: Upon request I will provide a summary of the Health Insurance Portability and Accountability Act (HIPPA) describing how medical information about you may be used.

Termination of Therapy: Both patient and therapist reserve the right to terminate treatment at any time. Therapists may end treatment for the following reasons: Untimely payment of fees, unable to pay fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, need for a higher level of care, need for a different type of care.

I have read the above and I understand and agree to the conditions stated.

Patient's Signature: _____ Date: _____
(if 18 or older)

Parent's Signature: _____ Date: _____
(if patient is under 18)

Financial Sponsor (if different from patient): _____ _____
Name *Signature*