

2100 N. Sepulveda Blvd., Ste. 27, Manhattan Beach, CA 90266

**General Information**

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

**The Therapeutic Process**

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

**Confidentiality**

The session content and all relevant materials to the client’s treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.

2. If a client threatens grave bodily harm or death to another person.

3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.

4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.

5. Suspected neglect of the parties named in items #3 and # 4.

6. If a court of law issues a legitimate subpoena for information stated on the subpoena.

7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert’s report to an attorney.

**Cancellation Policy**

Your appointment time is reserved for you. Therapy sessions are normally 50 minutes. Appointment cancellations must be made 24 hours in advance, otherwise, you are financially responsible for the cancelled/missed session(s). Insurance will not cover missed appointments or late cancellations.

**Payments Session Fee: \_\_\_\_\_\_\_\_**

Fees are payable at the time that services are rendered. Payment for services that are past due over 60 days may be subject to collection through the use of a collection agency or small-claims court. If such action is necessary, the costs will be included in the claim. However, before such action, efforts will be made to make other arrangements with you as needed.

**Insurance**

The therapists at One Heart Counseling Center are considered "out of network providers" for PPO health insurance plans. If you have a health insurance policy and would like to use your benefits to help cover the cost of therapy, we will verify your benefits and file claims for your sessions. The insurance company may send checks to you or to us. If the insurance company sends checks to you, please notify us so we can make arrangements for timely payment for your treatment. You should be aware that most insurance companies require your therapist to provide them with a clinical diagnosis, and sometimes additional information such as treatment plans. Finally, you should be aware that if you miss an appointment or cancel less than 24 hours in advance, you are responsible for the full session fee. A late cancellation or no show charge cannot be billed to your insurance and this is considered insurance fraud.

**Consultation**

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name or any identifying information. Additionally, due to the structure of One Heart Counseling Center, we do operate as a team in the sense that we provide one another support in the event of any emergency or threat. We only exchange information on an as needed basis and make every effort to preserve the highest level of your privacy possible while keeping the safety of all the highest priority.

**Outside the Office**

If we see each other outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

**Social Media Policy**

It is against the policy of One Heart Counseling Center to engage with any and all clients on social media sites such as Facebook or Linkedin. Please do not be offended if your therapist declines your request to connect in this manner. We want to make sure your privacy is protected and that the boundaries in the professional relationship remain clear.

**Patient Rights**

In addition to confidentiality, you have the right to end your therapy at any time, for whatever reason, without any moral, legal, or financial obligation, except fees already incurred. You have the right to question any aspect of your treatment with me, and to expect that I will work with you to meet your needs for adjunctive or alternative treatment. You also have the right to expect that I will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you, all of which would greatly compromise our work together.

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Name of Client

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Signature of Responsible Party Date

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Therapist Name and LIC#

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Therapist Signature Date