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Intern #63602

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Consent to Treatment

Client Name	Last	Middle	First
Address	Street	City, State, Zip	
Home Phone	Work Phone		Cell Phone
Emergency Contact	Name	Relationship	Phone

Dear Client:

I am looking forward to working together.

My view of psychotherapy is that you, as the Client, are hiring me, as the Therapist, to consult with you regarding growth issue or problems that significantly impact your life. The goals of therapy should be set by both the client and the therapist so that our agendas in working together can be clear and most effective.

The therapist/client relation is unique – personal, yet at the same time a business contract. In beginning our professional relationship, a clear understanding and agreement about the responsibilities and limitations of our professional relationship is important to ensure the delivery of the highest quality care. Please feel free to discuss any questions or concerns you have about these policies or any other matter at any time.

Appointments: Therapy sessions are 50 minutes long and begin at the scheduled appointment time. Telephone sessions are only available on an agreed upon basis or otherwise prearranged by you and myself. They are generally not a substitute for scheduled appointments. A prorated fee may be charged for telephone consultations or sessions longer than 15 minutes. In addition, you will be charged for all long distance telephone expenses.

Cancellation policy: Should you need to cancel a session, please do so by 9:00 A.M. on the day preceding the date of the appointment. Cancellations may be made by phone message if done in allotted time. Otherwise, the time will be held open, and you will be charged at your regular rate for cancelled or missed session unless it is due to a serious emergency.

Payment for services: All visits must be paid for at the time of visit or upon receipt of the monthly invoices, whichever is agreed upon between us. Invoices are mailed out on the last working day of the month. Payment is due within 30 days with balances carried over.

- (A) **Balance:** Unless otherwise arranged, balances carried forth into the next month will be assessed a 1.25% charge to be added to your new balance. If payment is not received for two successive billing periods, your account may be turned over to a collection agency. As this option is unpleasant I will make every reasonable effort to reach an accommodation with you.
- (B) **Insurance:** If therapeutic services are to be submitted to your insurance company you are still responsible for payment as described in paragraph (A) regardless of any insurance reimbursement you receive. Any exceptions must be mutually agreed to in writing prior to treatment. Please notify me at the start of treatment or when you have new insurance coverage so that I may prepare your invoice with the necessary information required for reimbursement. This will allow you to submit your invoice to your insurance administrator as a completed form adequate for reimbursement of an appropriate claim. Insurance reimbursements are to be made to you directly. I cannot accept responsibility for negotiating claims with insurance companies or other persons. With your written authorization, I will make any reasonable effort to provide information requested by your insurance company for the purposes of claims administration and evaluation.

Confidentially: I place high value on the confidentiality of the information that you share with me. Some personal information is required to be entered by me into your personal file, which is kept under my exclusive lock and key. However, I carefully avoid entry of information, which may be especially sensitive or embarrassing.

Any information you disclose will be maintained in the strictest confidence, unless you specifically authorize its release, or unless its release is required by law or professional standards of practice.

If for some reason there is a need to share information in your record with someone (for example, your physician or another therapist), you will first be consulted and asked to sign a form authorizing me to transfer the information. Because of the sensitive nature of the information contained in some records, you may wish to discuss the release of this material and related implications very carefully before you sign. The form will specify the information that you give me permission to release to the other party and will specify the time period during which the information may be released. There are several important instances when without your authorization the release of confidential information to others is required by law of professional standards of practice.

- (A) If you are involved in litigation of any kind and inform the court of the services you have received from me (making your mental health an issue before the court), you may be waiving your right to keep your records confidential. You may wish to consult your attorney regarding such matters before you disclose that you have received consulting or therapy.
- (B) A court order to release information is issued.
- (C) If you threaten to harm either yourself or someone else, and I believe your threat to be serious, I am obliged under the law to take whatever action seem necessary to protect people from harm. This may include divulging confidential information to others and would only be done under unusual circumstances where yours or someone else's life appeared in immediate danger.
- (D) If in my professional capacity, I acquire knowledge or a responsible suspicion that a child is being or has been abused or neglected, I am obligated by law to report this to the

appropriate agency. This law is designed to protect children from harm and the obligations to report known or suspected abuse or neglect are clear in this regard. Physical abuse of elders or dependent adults must likewise be reported. A report may also be filed in certain other circumstances involving elders/dependent adults.

In addition, there may be some other rare instances in which you waive your rights to have your records protected. If you are involved in any type of current or potential legal difficulties, I suggest that you discuss such matters with your attorney before informing others of the services you are receiving here.

Contacting therapist: I maintain a telephone voice mail answering service, Monday through Friday. In the event of an emergency, call 911. Although I attempt to return all calls in a timely fashion and emergency calls as quickly as possible, I cannot guarantee that calls, emergency or otherwise, will be returned immediately. I usually do not receive or return calls when I am in session. If you do not hear from me soon, please repeat your efforts.

Client Consent

I (" Client") acknowledge that I have read the above disclosures and policies, satisfactorily discussed any questions I have concerning them with Therapist, and agree to abide by them.

I do hereby seek and consent to take part in Treatment by Therapist. I understand that developing a treatment plan with him and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active and cooperative role in this process and in my therapy.

I understand that no promises have been made to me as to results of Treatment or to any procedures provided by Therapist. I authorize Therapist to obtain supervision or consultation about my treatment from colleagues as part of professional standards of quality assurance. Further I understand Therapist will be direct and honest in assessing the problems and likelihood of Treatment outcome.

I agree to pay for Treatment at the agreed upon fee per session, and I will pay for sessions not properly cancelled under the cancellation policy. I understand that the fee will periodically be reassessed but not more than every 6 months and with a minimum of 30 days notice. I authorize Therapist's clerical staff access to my records for necessary clerical functions, including billing and records maintenance.

I am aware that I may stop treatment with Therapist at any time, for any reason. The only thing I will still be responsible for is paying for services I have already received. However, I will make every effort to discuss my concerns about my progress with the Therapist before ending Treatment.

I am aware if there is an emergency during our work together, or if Therapist becomes concerned about my personal safety, he is required by law and professional standards of practice to contact someone close to me. He is also required to contact this person, or the authorities, if he becomes concerned about me harming someone else. On the Client information I have provided the person(s) I choose to be contacted in those situations, and I will advise Therapist of any changes.

My signature below means that I have read, understand and accept the conditions stated above and agree with all of the above statements.

_____ Signature of Client (or person acting for Client)	_____ Printed Name	_____ Relation to Client	_____ Date
_____ Signature of Client (or person acting for Client)	_____ Printed Name	_____ Relation to Client	_____ Date

I, Therapist, have discussed the above issues with Client (and/or his or her parent, guardian, or other representative). My observation of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ Joshua D. Wyner, PhD, MFT Intern "Therapist"	_____ Date
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