Searching Pathways Therapy
Robert Mitchell PhD
License # PSY 23699

Consent to Treatment

Psychotherapy is a relationship that works in part because of its clearly defined rights and responsibilities held by you and your therapist. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

My Responsibilities to You as Your Therapist

CONFIDENTIALITY:
I will keep confidentiality. I legally and ethically cannot and will not tell anyone about what we talk about, or even that you are seeing me without your prior permission. You have the absolute right to the confidentiality of your therapy. Please be aware that there are certain specific exceptions where confidentiality may be broken as described below:

1. If you are in imminent danger of harming yourself (e.g., planning to commit suicide).
2. If you seriously intend to harm another person, I must inform the police and attempt to inform the potential victim.
3. If you inform me of, or I have reasonable suspicion of child abuse, dependent adult abuse, or elder abuse, I am mandated to report that to the proper authorities. This includes instances of downloaded, streamed, or accessed through any electronic or digital media depictions in which a child is engaged in an act of obscene sexual conduct.
4. If you experience a treatment emergency. An example of this might be having a heart attack while in a session. If this were to happen, I would call 911.
5. In certain legal situations (e.g., court ordered, misrepresentation of services, breach of contract or ethical complaint).
6. Communication with your other health care providers (e.g., psychiatrist concerning medication evaluation).
7. Professional consultation or peer review. From time to time I consult with other mental health professionals who are bound by the same level of confidentiality. If your case were to be discussed, your name and other identifying information would be changed.

In all situations, I will always act so as to protect your privacy which means I will disclose the minimum amount of information necessary. I will be respectful of your privacy even if you release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time.

CHANCE MEETINGS:
If we see each other accidentally 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 if appropriate.

RECORD-KEEPING:
I keep treatment records in accordance with the laws and standards of my profession. In most cases, adult clients are entitled to inspect, request a copy, or obtain a summary of their records by submitting a written request. These are professional records and I recommend that we review them together to ensure that there is no misunderstanding of their content. If there is a reason why I can not directly share your records with you (e.g., viewing them would place you in physical danger), please know that I will be happy to send them to a mental health professional of your choice. I maintain your records in a secure location that cannot be accessed by anyone else.

DIAGNOSIS:
To be in compliance with my ethical standards, I diagnose the presenting issue. If a third party such as an insurance company is involved in your treatment, they normally require knowledge of this diagnosis. Diagnoses are specific and

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technical definitions that attempt to describe the nature of your issue. Knowledge of a diagnosis is sometimes useful to the client, but not always. Some feel great relief knowing that there is knowledge of their situation and that they are not alone. Others may feel stigmatized by being given a label. I may discuss this diagnosis with you if you wish. All of the diagnoses come from a book titled the DSM-IV; I have a copy in my office and copies of it are also found in most public libraries.

MANAGED MENTAL HEALTH CARE:
I will help with processing managed care. If your therapy is being paid for in full or in part by a managed care firm, there are usually further limitations to your rights as a client imposed by the contract of the managed care firm. These may include their decision to limit the number of sessions available to you, to decide the time period within which you must complete your therapy with me, or to require you to use medication if their reviewing professional deems it appropriate. They may also decide that you must see another therapist in their network rather than me, if I am not on their list. Such firms also usually require some sort of detailed reports of your progress in therapy, and on occasion, copies of your case file, on a regular basis. I do not have control over any aspect of their rules. However, I will do all that I can to maximize the benefits you receive by filing necessary forms and gaining required authorizations for treatment, and assist you in advocating with the MC company as needed.

OTHER RIGHTS:
I will be open with you about your treatment. You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think might be helpful. If you're unhappy with what's happening in therapy, I hope you'll talk about it with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. You can request that I refer you to someone else if you decide I'm not the right therapist for you.

ENDING THERAPY:
Therapy is expensive and I will inform you if I deem we have met our treatment goals and are no longer progressing therapeutically and for some people, ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

OFFICE POLICIES

FEES:
The current fee for a 50 minute session is $180.00. Longer sessions are charged on a prorated fee based on the normal 50 minute hour. Payment is made at the beginning of each session unless other firm arrangements were made in advance. This office accepts cash, checks, and major credit cards (Visa, MasterCard, AMEX, Discover). Emergency phone calls of less than ten minutes are normally free. There is a prorated charge for: 1) calls lasting more than 10 minutes in a week; 2) leaving more than 10 minutes worth of phone messages in a week; 3) sending emails that take longer than 10 minutes to read and respond. Fees may increase every year. If a fee raise is approaching I will remind you of this well in advance.

SESSION START TIME:

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Please be prompt for your session. Late sessions still end on time as to not run over into the next client's session.

CANCELING A SESSION:
There is no charge for sessions cancelled with more than a 24 hour notice. Cancellations and re-scheduled session will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

ADDITIONAL FEES:
Payments, co-payments, and deductible amounts are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date. There is a charge for returned checks (set by the bank and $35 at the time of the writing of this document)

TELEPHONE ACCESSIBILITY:
If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that Face- to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911 or any local emergency room.

INSURANCE:
This office will generate service statement at the end of each month upon request for clients who wish to use their insurance coverage for their psychological services. Clients are reimbursed by submitting their insurance generated form and attached service statement to their insurance carrier. At present, this office does not directly process insurance forms.

SOCIAL MEDIA AND TELECOMMUNICATION:
Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION:
I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and I chose to use information technology for some or all of your treatment, you need to understand that: (1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. (2) All existing confidentiality protections are equally applicable. (3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee. (4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent. (5) There are potential risks, consequences, and

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benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

MINORS:
If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

ENDING THERAPY:
Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

Client Consent to Psychotherapy

I, _____, authorize and request that Robert Mitchell PhD. to provide psychotherapeutic treatment, clinical evaluation and diagnostic procedures which are advisable and mutually agreed upon during the course of my care as a client. The frequency and type of treatment will be decided on as the therapy proceeds. I understand that the therapeutic process will be explained to me on an ongoing basis. I have also been provided with the HIPAA agreement and have been informed that I may access a copy of it at www.SearchingPathways.com.

Client (or first partner) Signature _____ Date_____

Second Partner (if applicable) Signature _____ Date_____

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