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**Informed Consent and Authorization for Psychotherapeutic Treatment**

Life is about relationships, and marriage and family therapists specialize in helping people with relational issues. I strive to empower couples, families, and individuals to live a life of greater happiness and deeper, more meaningful connectivity. I believe that a positive sense of self is closely related to the health of our most important relationships. As a marriage and family therapist, it is my honor to join couples, families, and individuals in their unique journeys of transformation as we work to expand inner growth and restore relational bonds.

In addition to being a clinical process, therapy involves a professional arrangement, regulated by laws, ethics, your rights as a client, and my standard business practices. Before therapy can begin however, your agreement to the business policies described herein is required.

This Therapist-Client agreement is effective as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date) between Jodi Stanley, Psy.D., LMFT, a licensed marriage and family therapist, (#42544), and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(client(s)).

**CONFIDENTIALITY LIMITS AND EXCEPTIONS**

In general, you have a right to privacy concerning your medical information, which means the information you share with me and the content of our work together will be kept confidential. I am legally required to keep this information safe and secure and I can only release information about our work to others with your written authorization.

However, there are some exceptions designated by California law in which disclosure of your medical information may be required or permitted. Some of the most common situations in which I am mandated to disclose your confidential information include the following:

1. If you disclose information to me that leads me to suspect that a child has been abused physically, sexually, or mentally, neglected, or endangered, I am required to report that information to Child Protective Services or law enforcement;
2. If you disclose information to me that leads me to suspect that an elder or dependent adult has been abused physically, sexually, mentally, or financially, neglected, abandoned, isolated, or abducted, I am required to report that information to Adult Protective Services or law enforcement;
3. If you communicate a serious threat of bodily harm against yourself or against a reasonably identifiable victim(s), and I believe you have a deadly weapon or other means of implementing harm, I must report that information to law enforcement and notify the potential victim;
4. Although I will protect your medical information if requested to testify during legal proceedings, if ordered by a court, board, commission, or administrative agency to disclose your medical information, I must comply with such order.

It is my ultimate preference to obtain your written permission prior to disclosing your medical information. However, in certain circumstances I am authorized by California law to disclose information about our work together without your written consent. Some of the most common situations in which I am permitted to disclose your confidential information include the following:

1. Submitting invoices to third party payers, including insurance companies, to obtain reimbursement for my services provided to you;
2. Consulting with your physician/psychiatrist, or other mental health professionals about your diagnosis and/or treatment. During consultations, all consultants are legally bound to keep the information confidential;
3. I also implement a *‘No Secrets’* policy for clients that are involved in couples therapy. Information that one partner shares with me without the other partner present may be discussed during conjoint sessions.

**LIMITS OF COMMUNICATION**

Every effort will be made to assist you, especially during crisis. However, there may be times when I am not immediately available. I monitor my voicemail and emails frequently and respond to messages within 1 business day, with the exception of holidays. If you are unable to reach me and feel that you cannot wait for a return call, contact your family physician or the nearest emergency room to obtain assistance from an on-call psychologist, psychiatrist, or Mental Health worker. If you experience a mental health emergency, please contact San Diego Crisis line at 1-800-479-3339 or call 911.

You may contact me by calling 619-559-9614; by mailing correspondence to 2851 Camino del Rio South, Suite 300, San Diego, CA 92108; or by emailing jstanleymft@gmail.com. Please note email and text communication is for non-emergencies only, is not a secure method for sending confidential information, and should be reserved for scheduling, referrals, and non-clinical questions only.

Consistent, timely attendance at sessions is fundamental to achieving success in therapy. As a standard business practice, each appointment ends (50) minutes from the scheduled start of the appointment, regardless of your arrival time. Please arrive on time as I am not able to extend sessions.

Telephone calls exceeding 10 minutes will be billed on a pro-rated basis based on your fifty minute session fee.

With regard to the treatment of minors, it is my policy to provide parents with general information about the minor’s progress in our work together, unless I reasonably believe there is a risk of the minor seriously hurting him or herself. In this case, parents or guardians are notified immediately of my concerns.

**TREATMENT TERMINATION**

Ideally, therapy ends when we mutually agree your treatment goals have been achieved.

You have the right to terminate our work together at any time by notifying Jodi Stanley, Psy.D., LMFT of this intent at least 24 hours prior to next scheduled session. Referrals can be provided to you upon your request.

Jodi Stanley, Psy.D., LMFT may terminate treatment with cause only, including but not limited to:

1. Failure to comply with any of the terms of this agreement;
2. If I reasonably believe you are not benefitting from our therapy sessions;
3. If I believe I can no longer provide you with effective treatment because your condition requires treatment outside of my scope of practice and/or scope of competence;
4. If you attempt to involve me in issues that are, or could be, illegal, unlawful, and/or unethical.

**RISKS ASSOCIATED WITH PSYCHOTHERAPY**

Like many things in life, psychotherapy has inherent risks. Some of these risks to you are:

1. Disruptions in your daily life that can occur because of therapeutic changes;
2. Emotional pain due to exploring personal issues and family history;
3. Experiencing emotional pain within your current relationships;

Although therapy begins with the hope that your life and relationship(s) will improve, there is no guarantee that this will occur.

**PAYMENT OF FEES**

The session fee is $175.00 per fifty (50) minute session, payable at the end of each session. I accept cash, check, Venmo, credit/debit, or HAS/flex spending accounts. All checks payable to Jodi Stanley. A $20 returned-check fee will be assessed if necessary.

If you request services in addition to session appointments, you will be charged the same hourly rate. This applies to services including preparation of records or treatment summaries, composition of written evaluations, authorized telephone consultations, attendance at meetings with other professionals that you request, or reading and responding to lengthy emails.

If you become involved in legal proceedings that require my participation to testify about your treatment, you will be billed $200.00 per hour.

I do not accept insurance; however, if you choose to utilize out-of-network benefits it is your responsibility to request a superbill from me, to submit claims for reimbursement to your insurance company, and to follow up on the status of submitted claims.

If you must miss a scheduled session for any reason, I require a 24 hour notice by phone or email. This policy allows me the opportunity to offer the time to other clients as well as to maintain a consistent caseload. If you do not abide by this cancellation policy, you agree to compensate Jodi Stanley, Psy.D., LMFT $175 for the missed session and the inability to schedule other clients at that day/time.

**CREDIT CARD AUTHORIZATION**

A current credit card number must be on file at all times, regardless of your preferred method of payment. Your card will not be charged if you choose to pay by check or cash at the time your payment is due. All paid invoices are emailed to the card holder at time of the charge.

All outstanding balances remaining unpaid for more than 30 days will be charged directly to your credit card. If the credit card does not authorize payment, you are subject to interest accrued at a rate equal to 10% of your outstanding balance.

The undersigned hereby authorizes Dr. Jodi Stanley to charge the credit card provided below for the amount of any unpaid balance over 30 days old and for “no show or late cancellation” fees.

**Credit Card Information**

Please Circle: Mastercard Visa American Express

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name as it appears on the card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address with zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of card holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION TO COMMENCE PSYCHOTHERAPY**

Your signature below verifies that you have read (or that I have read to you) the information in this authorization and that you asked questions about anything you have not understood up to this point. By signing, you freely acknowledge your willingness to undergo treatment using psychotherapy methods, as I deem appropriate and in accordance with this ‘Informed Consent.’

You also agree to enter into a professional business arrangement according to all business practices outlined in this agreement. You accept total financial responsibility for payment of all fees and services as described, regardless of insurance coverage or any other ‘third-party’ payers.

You will also be releasing me of any liability that directly or indirectly results from disclosure or exchange of any information covered in this agreement. At your request, a copy of this and any other document in your record that bears your signature will be provided.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Parent Signature Today’s Date

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Client/Parent Signature Today’s Date