Informed Client Consent and Treatment Contract

Instructions

Please read and initial the following information. If there is any part you do not understand or if you would like more clarification, please ask for further explanation before signing at the end of the form.

Consent to Treatment

___I request, consent to, and authorize Rakel Delevi, Ph.D., Licensed Marriage and Family Therapist to provide all therapeutic and psychological services that may be deemed advisable or necessary for me/my child.

___I acknowledge and accept that it is my responsibility to discuss my goals and needs with Dr. Rakel and that she will present possible approaches to these goals and needs.

___I acknowledge and accept that, while many people find the type of services offered by Dr. Rakel to be helpful, I/my child may not find therapy to be helpful. I understand that I may end therapy for myself/my child at any time.

Confidentiality and Privilege

___I understand that Dr. Rakel adheres to standards of confidentiality and privilege defined by ethical therapeutic practice. This means that she will not release any information regarding me/my child to anyone without prior consent.

___I acknowledge and accept that there are exceptions to confidentiality and privilege, which arise from certain California legal mandates. These exceptions are:

___The duty of reporting to authorities, without the client's consent, any suspicion of the abuse, endangerment, or neglect, either physical or sexual, of any child or dependent adult—whether such abuse is occurring, occurred recently, or occurred in the past;

___The obligation to warn the intended victim and the authorities when it appears that the client, or a person known to the client, intends to hurt another person;

___The need to take appropriate steps when it appears evident that the client will most probably make a suicide attempt to prevent such an attempt; and

___When disclosure is required pursuant to a legal proceeding.

___Should Dr. Rakel need to break confidentiality for one of the above reasons, she may attempt to inform me that a report or disclosure will be made. She may also encourage me to make any report to authorities myself. I have the right to discuss my feelings about any reporting situation with Dr. Rakel.

Cost of Services

___I understand that the fee for therapy with Dr. Rakel is $_____ per 50-minute session. Longer sessions and telephone calls over ten minutes in length may be charged on a pro-rated basis. Payment is due prior to the beginning of each session.

___I understand that, if it will be a hardship for me to pay the full fee, I must discuss this in advance.

___I understand that there may be additional resources available to pay for my therapy through the State of California Victims of Crime Program or my insurance. I understand that there are specific requirements for these programs and that Dr. Rakel makes no representation as to my eligibility. It is my responsibility to contact the Victims of Crime office or my insurance directly to inquire about potential benefits. I am fully responsible for payment of all fees for therapy and for discussing payment options with Dr. Rakel.

Appointment Timing and Cancellations

___I understand that individual therapy sessions are 50 minutes in length and begin on the hour. If I am late for my appointment, my session will still end at 50 minutes past the hour. Group therapy sessions will begin and end as scheduled.

___I acknowledge and accept that any time I need to cancel an appointment, I must contact Rakel at least **48 hours** in advance. I understand that if I do not do this I will be charged for the missed session.

Therapist Availability

___I understand that I may call Dr. Rakel's confidential voicemail at (310) 993 3640 any time to leave a message and that, while she responds to all messages as quickly as possible, Dr. Rakel may not call me back immediately.

___I understand that Dr. Rakel, occasionally travels, and may not be available by phone or in person. During these times, she can provide the name of another therapist who I may contact if the need arises. I will be responsible for any emergency sessions I schedule with that person.

___I also understand that Dr. Rakel is available by phone between sessions primarily for scheduling appointments. She is available for emergency calls but will charge me for calls that extend longer than ten minutes. If I need to discuss something at length, I will schedule an appointment.

___I agree that, in any potentially life-threatening emergency, I will contact 911 or other appropriate authorities immediately.

Signature

I have read, understand, and accept all of the above and have received a copy of this form.

Name (Print)	Signature	Date
Relationship to Client	Client's Name	