Please read the following information that was prepared to help you know what to expect in your initial meetings with me. I hope you will keep this information in a safe place for future reference. You must sign the Consent to Treatment on the last page and give that page to me before beginning treatment.

Therapy Process

Psychotherapy is an exciting journey into healing and growth. The success will depend on my skill, our interpersonal connection, and your motivation and efforts devoted to self-reflection, honesty, experimentation, openness, and desire for change. The magnitude and rate of personal change are determined by our joint efforts.

Parents of children in therapy are invited to schedule consultations with the therapist on a monthly basis so that they can be partners in the treatment process. Any communication with the child's therapist should happen by mail, by telephone message, or at the consultation meetings so that the child does not overhear such conversations and so the child is not required to shorten his or her session in order for the parent to talk to the therapist. In most cases, it is beneficial for children to know that parents are communicating with the therapist and are full partners in the therapy process. However, therapy is most effective when the contents of a child's session are privileged and confidential unless certain circumstances require disclosure (see Confidentiality guidelines below).

Benefits and Risks; Consumer Rights

The benefits of therapy are many and profound, including reduction of distressing symptoms, increased insight and behavioral flexibility, possibilities for deeper spirituality, and deeper connections to others. The risks include discomfort resulting from experiencing painful feelings or from decisions to make life changes. You have the right to ask questions about any aspect of psychological services at any time. You have the right to

withdraw from treatment at any time. You may ask for appropriate referrals at that time. You have the right to make written requests to me to release information to other professionals involved in helping you.

Emergencies

If you have a life-threatening emergency, you must call 911 or go to the nearest emergency room. If you need to reach me, please telephone (703) 981-3670 and leave a detailed voice message in my voicemail. If for some reason you do not hear back from me within the hour and feel you need to speak with someone, you may page my colleague, Andrea Davis, Ph.D. at (626) 728-5640 and follow her emergency procedures. Some numbers which might also be of assistance: Pasadena Mental Health (626) 709-0907; Las Encinas Hospital (626) 795-9901; Huntington Hospital (626) 397-2324; L.A. County/USC Medical Center (323) 226-5598.

Fees

Session fees are $170 unless otherwise negotiated with Dr. Davis or myself. Fees can be paid at the time services are rendered by credit card, cash or check (made out to Greenhouse Therapy Center). They may also be paid monthly if an arrangement is made to do so. It is well known that therapy proceeds best when there is no outstanding balance to complicate your feelings about the therapy and the therapist. If you request letters, reports, or require telephone conversations between sessions that involve an extensive commitment of time, you will be billed at a rate of $37.50 per quarter hour increment for these services. Clients are encouraged to openly discuss any issues concerning the fee and the billing process.

Cancellations

When you reserve a specific or a standing appointment time, you are responsible to pay for that session unless you free that time block for use by another client by canceling within sufficient time for the session to be utilized. Cancellations are discouraged because they interrupt the treatment process that depends on the rhythm and regularity of contact with the therapist. If you find you must cancel your normal session time, I may be able to reschedule your session for another time. If you are on a trip, have a transportation difficulty, or are ill, I welcome you to utilize a telephone session in place of an office visit. Most cancellations can be avoided in this manner.

Health Insurance Claims
If you choose to submit claims for therapy services to your medical insurance company, you will need to meet the criteria for an official diagnosis. Also, if you use insurance, basic information about you such as diagnosis, goals, progress, and treatment plans will typically be released to your medical insurance carrier. I cannot guarantee the confidentiality of your information once I send it to your insurance company. Any co-payments, deductibles, denied charges, and **charges for missed appointments** at the full session rate are your responsibility to cover (insurance does not cover your missed appointments).

Confidentiality
One of the powerful factors involved in developing a healing relationship is confidentiality. I will not disclose any information about you without your explicit request. Even the law recognizes that information shared between a counselor and a client is privileged. However, the law requires that I must release information in the following situations: 1) if I have a reason to suspect child, spousal, or elder abuse, 2) if I am aware that you become a danger to self or others, 3) if a judge orders me to release your records to the court, or 4) if you have chosen to make your mental state an issue in a legal proceeding. Nevertheless, in order to protect the confidentiality of all the information you share with me, **you need to agree that neither you nor your attorney will ask or subpoena me to testify in court or release your therapy records to an attorney or judge.** Your signature on the Consent to Treatment attests to this agreement.

Minors, Couples, and Families
If you are under eighteen years of age, the law may provide your parents the right to review your treatment records. It is my policy to request an agreement from parents that they relinquish access to your records. If they agree, I will provide them with only general information about our work together unless there is concern that someone may be hurt. In couple or family sessions where there are two or more participants attending therapy regularly together, I have a “no secrets” policy in which all information shared by participants is shared with everyone involved in sessions. This allows us to work more freely together.

Completion of Therapy
Therapy is complete when you and I believe that you can maintain your growth on your own. The ending of therapy is an important part of the treatment as it is a time to consolidate gains and explore potential growth areas related to separation and loss. It should be given adequate time relative to the time spent in therapy. Please discuss with me any thoughts you have about finishing therapy so a plan can be generated together. Parents in particular are urged to plan far in advance for this important process when considering ending their child's therapeutic work.

Consent to Treatment

I have received a copy of Office Procedures & HIPAA notice. I consent to therapeutic services for myself (or for my child).

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Signature Date

____

Name Name of child (if applicable)

Three Goals for Treatment (Specific Desired Outcomes)

1. ____

2. ____

3. ____

____

Client Age Client Birth date Home Phone Work Phone Cell/Pager

____

Home Address/Phone

____

Emergency Contact – Name/Address/Phone

____

Client's Physician – Name/Address/Phone

____

Medical Conditions

____

Hospitalizations – Dates of Admission/Discharge/Reason

____

Prior and Current Medications – Drugs/Dates/Reason

____

Current Alcohol and Drug Use – Frequency/Amount

____
Previous Counseling or Psychotherapy or Evaluation – Professional's Name/Dates/Reason

____
Who referred you?