Grace Kuo, M.A, LMFT 101249
(818) 583-7179
913 E Walnut St
Pasadena, CA 91106

Informed Consent

Welcome! This document contains important information about my professional services and business policies and how they may affect you. Please read this document carefully and make note of any questions or concerns you may want to discuss with me. Once you sign this document, it will become a binding agreement between us and also provide your consent for us to begin therapy.

Benefits and Risks; Consumer Rights

Therapy is a unique and highly individual experience with the outcome determined by the effort and motivation you bring to work towards a change in yourself and how you see the world around you. It can result in a number of benefits to you and can potentially help in your ability to detect, challenge, and change beliefs. Therapy also has the potential to help you gain new or deeper understandings about your issues and learn new ways of coping and solving them.

However, there is no guarantee that therapy will yield positive or intended results. Because feelings will be explored, you may feel a range of emotions that can be intense and uncomfortable at times. I encourage you to explore those feelings during our sessions, as they are part of the therapeutic process. In the attempt to resolve issues that originally brought you to therapy, unintended changes in your personal and interpersonal relationships may result.

Our therapeutic relationship is strictly voluntary. At any time during our work together, you have the right to decide to end treatment. If you are thinking about ending therapy, I encourage you to discuss it with me, and if you wish, I will be glad to provide you with the names of other mental health providers. During the course of therapy, if I assess that I am either unable or not effective in helping you reach your therapeutic goals, I will discuss this with you, and if appropriate, terminate treatment. I will provide you with appropriate referrals and assist you in the transition to a new therapist if you so desire.

Meetings

Individual therapy sessions last 53 minutes per session and will begin at the time agreed with you. Typically, therapy sessions take place on a weekly basis, at a mutually agreed time. There are times depending on your treatment plan that more sessions per week may be applicable as well.

Couples or marital therapy require three assessment sessions along with an online assessment. These include one joint session for 60 minutes and two individual sessions

for 45 minutes each. The 4th meeting is a joint feedback session. After the 4th meeting, there will be intervention sessions at 60 minutes taking place once a week.

Pre-marital therapy is a 12 week program with once a week 60 minute sessions.

Cancellations and Rescheduling

If you need to cancel or reschedule a meeting, please notify by contacting me at least 24 hours in advance of our scheduled meeting to allow time for rescheduling and allowing others who may desire that time slot to be scheduled in. There is a $100 late fee for each late cancel or no show. Two (2) late cancels and/or no shows in a year may result in terminating services. Maintaining scheduled appointments are important to the therapeutic process. Keep in mind that insurance companies do not cover or reimburse you for missed sessions or late cancellations. ***Cancellations for Monday appointments must be notified on the previous Friday.

Fees and Payment

Initial intake assessment sessions for **individual therapy** are **$200** with follow up sessions at **$150** per 53 minute sessions.

Couples or marital therapy is **$700** for the 3 initial assessment sessions and joint feedback session. Follow up intervention sessions are **$170** per session. Payment plans can be made.

Pre-marital therapy is **$2040** for the entire 12 weeks. Payment plans can be made.

Payment for individual therapy sessions must be paid at the start of session so that we can maximize your therapy time. Your session fee may be increased annually. In the event of any fee changes, you will be notified at least 30 days prior to such changes.

Upon our first session, you will need to complete a credit card authorization form. The card will be stored via Ivy Pay which is HIPAA compliant. You may use this card for payments. It will also be the card used to charge for any late fees/no shows.

Couples/marital/pre-marital therapy are **cash pay**. Medical insurance is not accepted.

Health Insurance Claims

If you choose to use medical insurance company to cover psychological treatment, the patient will need to meet the criteria for a formal psychological diagnosis. Also, if you use insurance or any third party payer, basic information about you such as diagnosis, goals, progress, and treatment plans will be required from us. We cannot guarantee the confidentiality of your information once we send it to your third party payer. Any co-payments, deductibles, denied charges, and charges for missed appointments are your responsibility to cover. Insurance will not cover any payment for missed appointments,

therefore you will be responsible to pay the late cancel/no show charge (not just the copayment amount).

Additional Fees
If you request letters, reports, or telephone conversations that exceed 15 min., you will be billed at a rate of $ 37.50 per quarter hour increment.

Contacting Me
You may contact me during my office hours at (818) 583-7179 Monday through Friday from 8:30am-5:30pm. I will try my best to reach you within 24 hours of your phone call. On weekends or holidays, I will only return calls in cases of emergency, otherwise I will return calls on Monday or the day after the holiday.

Email Usage
By nature, therapy is confidential. You can have the confidence that your insights, vulnerable experiences, and feelings will not be repeated outside the therapeutic relationship established. By nature, email correspondence is NOT confidential. Please be advised that communication through the internet may have security risks.

My policy regarding email usage is as follows:
• Email correspondence with me is NOT secure.
• Email correspondence is NOT a substitute for person-to-person therapeutic treatment, unless discussed with me in advance and in person.
• Email correspondence will not play a part in your therapy except for scheduling purposes.
• Email correspondence is NOT to be used in the case of an emergency to contact me.
• If you need to contact me with something that demands immediate attention, you will do so by voicemail at the following number: (818) 583-7179, call 911, or go to the emergency room.
• If it becomes necessary, I will terminate treatment if email usage has or becomes inappropriate.

Emergencies
If you are experiencing a life-threatening emergency and need to talk to someone immediately, you can call 911, the police, or your local hospital emergency room and ask for the psychologist or psychiatrist on call.

Confidentiality
One of the powerful factors involved in developing a healing relationship is confidentiality. We will not disclose any information about the client to outside parties

without the client's or guardian's explicit request. However, the law requires that mental health professionals must release information without consent in the following situations: 1) if there is reason to suspect abuse of any child, spouse, elder, or dependent adult, 2) if the client is deemed a danger to self or others, 3) if a judge orders us to release client records to the court, or 4) if you have chosen to disclose the client's mental state in a legal proceeding. Nevertheless, in order to protect the confidentiality of all treatment information, **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.**

Other exceptions include: per your signed release, I may discuss your case with supervisors or peer counselors in order to provide excellence in the service I give and in accordance with accepted professional behavior. In doing so, I will keep your identity or any details allowing your identification confidential.

When working with minors, confidentiality will be kept unless there is a concern that the child is in danger to themselves, someone else, or has been harmed. In these cases, the guardian(s) will be notified of the concern and if possible, I will have discussed the matter with the minor and have done my best to handle any objections he/she may have. During treatment, I will provide the guardian(s) with only general information about the progress of treatment and the attendance of scheduled sessions.

Limitations on Confidentiality when Providing Therapy to Families or Couples

This written policy is intended to inform you, the participants in therapy, that when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties.

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

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However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it is necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This "no secrets" policy is intended to allow me to continue to treat the couple or family by preventing a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

Completion of Therapy

Therapy is complete when therapist and client believe the client can maintain the rate of growth independently. 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. The treatment relationship should not be stopped abruptly but rather should be given adequate preparation and reflection time relative to the time spent in therapy. Please discuss with the therapist any thoughts about ending therapy so that a plan can be generated together. If we have not had a session in over one (1) month and client has not responded to attempts for rescheduling, a letter will be sent out, and your file will be closed.

Agreement

I have read this information fully and completely. I have discussed any questions I had about the information, and I understand the information. I acknowledge that it is my choice to participate in psychotherapy (or have my child participate). I realize that the outcome of therapy depends upon my personal investment in the therapy process. I have familiarized myself with the fees and charges for services provided by Grace Kuo, LMFT of GreenHouse Therapy Center.

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_____	_____
Name of client (printed)	DOB
_____	_____
Signature of client	Date
_____	_____
Name of child (printed)	DOB
_____	_____
Signature of child or guardian	Date
_____	_____
Signature of therapist	Date

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Credit Card Authorization Form

Credit Card Information	
Card type	
Cardholder name: (as shown on card)	
Card number	
Expiration date (MM/YY)	
Cardholder zip code	
Security code	

I, _____, authorize Greenhouse Therapy Center to charge my credit card above for agreed upon services. I also understand that my information will be saved to file in Ivy pay and be used for late cancel and/or no show charges.

Client signature: _____ Date: ____/____/____