Leah H. Rosenthal, Ph.D.
Clinical Psychologist PSY 18036
925 The Alameda, Suite 24, Berkeley, CA 94707
Telephone: (510) 244-1732

Informed Consent to Treatment

This is information regarding your rights, and the benefits and limitations of psychological treatment, so that you may give fully informed consent should you decide to proceed with psychotherapy. The guidelines and wording of this document follow recommendations by the Board of Psychology of California. Feel free to discuss any concerns or questions you may have after reading it through. When you sign this document it will represent an agreement between us.

The Process of Psychotherapy

Work in therapy is a joint effort; progress and length depend on many factors including motivation, life circumstances, and the nature and severity of the issues for which you are seeking help. Talk therapy is one of many approaches available for addressing psychological problems and it may not resolve the difficulties with which you are concerned. There are treatment alternatives that we can discuss during our initial sessions if indicated. Although it is designed to be helpful, therapy may at times be uncomfortable or emotionally painful and the potential exists for disruption in your life when change occurs. Your participation in psychotherapy is voluntary and you are free to withdraw or to seek consultation from another professional at any time. I will also refer you to another therapist if I believe that my professional training makes me unqualified to deal with a specific problem for which you are seeking help.

Our first one to three sessions will involve an initial evaluation of your needs. Sessions are spent confidentially discussing your reasons for meeting, gathering background information, and talking about the process of therapy. By the end of our first sessions, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow. Please evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have questions about my approach, I encourage you to discuss them with me whenever they arise. If you ultimately decide not to continue working with me, then I would be happy to give you referrals to other mental health professionals.

Payment and Cancellation

Once we agree on one or more regular times per week, I will reserve those hours for you and expect payment for them. If you wish to cancel your appointment and give me 48 hours notice, then you will not be charged. If you cancel within 48 hours of the appointment or do not attend, then you will be charged for that session. I will give you advance notice of my vacations or planned absences and I expect that you will do the same.

Insurance & Reimbursement

If you plan on using insurance, it is very important that you find out exactly what mental health services your insurance policy covers for in-network or out-of-network providers. You should carefully read the section in your insurance coverage that describes mental health services. If you have any questions about the coverage, call your plan administrator. You (not your insurance company) are ultimately responsible for full payment of my fees should my services not be covered.

It is sometimes difficult to determine exactly how much mental health coverage is available. Managed health care plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Some managed care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy if desired. Once we have all the information about your insurance coverage, we will discuss what we can accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions.

Please also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. I will provide you with a copy of any report I submit if you request it.

Below I authorize the release of any medical or other information necessary to process insurance claims to Leah H. Rosenthal, Ph.D. I authorize payment of medical benefits to Leah H. Rosenthal, Ph.D. for the services described.

Client Signature:_____ Date:_____

Minors

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement with parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss this matter with you and do my best to handle any objections you may have about what I am prepared to discuss.

Confidentiality

Privacy is a basic right of any individual who seeks psychotherapy. Information from our sessions is confidential and legally privileged. I maintain limited treatment records, psychotherapy notes, and billing information as required by the laws and standards of my profession. No information will be released without your (or your legal guardian's) written consent, except under the following circumstances:

1) If I believe that you are in danger of physically harming yourself, I may disclose relevant information in order to maintain your safety.
2) If I believe that you are in danger of physically harming someone else, I may disclose relevant information in order to maintain both of your safety.
3) If you disclose to me any circumstances that lead me to suspect that a child, adult or dependent adult is being neglected or abused, I am required to report this to a designated agency.
4) Should I seek consultation with a professional colleague, I will make every effort to keep your identity strictly confidential, as well as their being legally bound to maintain confidentiality.
5) Information and records must be provided in the event of a court order and in litigation or official proceedings as required by law.
6) Confidentiality and privilege do not apply between members of a couple or family in treatment. I will rely on my clinical judgment to decide whether to reveal information to participating couple/family members or to the parents of a minor in treatment.
7) Third party payors (e.g. insurance companies) may request information for billing, reimbursement and/or to authorize treatment.

Privacy Policy & HIPAA

My privacy policies are also directed by a federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA mandates that I take certain privacy measures when storing, using, or transmitting your Personal Health Information (PHI). In brief, I may disclose your PHI for routine matters of treatment, such as communicating with other health care professionals treating you (though it is my policy to acquire a written consent from you most instances); in matters of payment, such as billing and collecting payment; and routine health care operations, such as billing a third party insurance company.

Along with this informed consent paperwork, I have provided you with a copy of a detailed explanation of your rights guaranteed by HIPAA. Please read over these privacy rights and let me know if you have any questions about them.

I have received the *HIPAA Informational Sheet* (Initial here) _____

Emergencies

My office telephone number is (510) 244-1732. You may leave me a confidential message here at any time. In the event of an emergency or crisis please leave me a message and also contact other appropriate persons such as the Police, 911, the nearest hospital emergency room, your physician, and psychiatrist. I will make every effort to get back to you as soon as possible. In the event that I am away on a planned vacation or absence, I will leave the name of another clinician on my voicemail whom you can contact for urgent consultation if necessary.

Please sign below if you have read, understood, agree to these guidelines, and give consent to treatment. Thank you.

Client Name: _____ Date of Birth: _____

Client Signature: _____ Date: _____

Telephone: _____ Email: _____

Address: _____

Insurance: _____

Group #: _____ Member ID: _____