Michele Sherman, MFT
Marriage Family Therapist

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(818) 725-2488

INFORMED CONSENT FOR RECEIVING PSYCHOTHERAPY

Welcome to my office. As a psychotherapist, I am governed by various laws and regulations and by the code of my profession. The Ethic Code requires that I make you aware of specific office policies and how these procedures may effect you. However, many of these policies will be unrelated to our work together.

Some Dimensions of Psychological Care:

You are seeking therapeutic services because you want to make some changes in your life. While I will help you attempt to achieve these goals, I cannot guarantee that the outcome will be what you now seek. That is because the work depends on your sustained commitment, flexibility, and even sometimes your courage. You may also find that the new knowledge and perspectives emerging in your sessions may modify your notions about what it is that you need to achieve or about what might be beneficial for you. Additionally, because psychological work is always part art as well as science, it may not move in precisely those directions you anticipate; you may have to bear with some feelings of frustration or confusion.
Your sessions may sometimes be trying for you. Change is often accompanied by feeling states that can be distressing and by periods of some internal turbulence. As the work proceeds, you may experience moments of frustration, some anxiety, feelings of depression, increased self doubt, and episodes of feeling conflicted about some issues in your life. At the conclusion of our work together, you may find that many things about your life which you had not originally anticipated may have altered: e.g., some of your values and beliefs, your view of your past, the nature of your relationships, your career aspirations and/or your wishes for the future. These are only a few of the possible alterations that might result from your sessions.

Contacting Me
I can be reached by calling (818) 725-2488. Calls received after 9 PM will be returned the following business day. If you are calling regarding an emergency, please leave a message indicating so and I will return the call as soon as possible. In the unlikely event that you cannot reach me, contact your family physician, or your local emergency room and ask for the or dial 911. Whenever I am unavailable for an extended period of time I will place someone on call for me. That person's name and number will be accessible by calling my voicemail while I am unavailable.

Confidentiality
Information revealed within sessions will remain confidential unless disclosure is required by law (e.g., where there is reasonable suspicion of child, dependent, or elder abuse; when the patient is of danger to others; or when the patient is likely to harm him or herself unless protective measures are taken). If there is ever a time when you enter your emotional status as an issue in a legal proceeding, i.e., child custody evaluation, Workmen's Compensation claim, etc., then you may be waiving your right to the confidentiality of this relationship. Case material may be discussed with another colleague or in the context of ongoing educational and teaching activities, but only when personal information regarding the patient is so altered as to

render the patient unidentifiable.

Payment for Services

The fee for outpatient psychotherapy is $180.00 per session, unless otherwise arranged.
Patients are expected to pay for services at the time they are rendered. Delinquent accounts, namely accounts that are more than 90 days late will be referred for collection. Bank charges on returned checks are the patient's responsibility, and there will be additional charge of $35.00 for my financial institution fees.

Insurance Reimbursement & Assignment of Benefits: Assignment of benefits:

I the undersigned certify that I have insurance coverage with _____and assign directly to Michele Sherman MFT, all my insurance benefits. I understand that I am financially responsible for charges, whether or not paid by my insurance. I hereby authorize Michele Sherman, to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

Appointments

The standard session is 45-50 minutes.

Vacations

I generally take between two and four weeks of vacation during the year. I will give you advance notice as to when I will be away.

Professional Records

Both California Law and the standards of my profession require that I keep appropriate records of services provided. The confidentiality of these records is closely safeguarded. The records are kept in a locked cabinet and both my office and the suite are locked at night.

Release of Information

Should I be required to communicate with a third party regarding the confidential treatment relationship, i.e., an attorney, a judge, or school, or other institution, then a separate "Release of Information" form will be provided and signed by the patient before any such exchange or information occurs.
Your signature on the accompanying form acknowledges that I Michele Sherman, MFT, discussed this information sheet with you as well as elaborated further on my business policies, limits of confidentiality, and nature of the treatment process. Your signature also indicates that you have read and understood this document and have also been provided with a copy.

Cancellations

Clients are responsible for payment of agreed upon fee of $180.00 (unless otherwise arranged in writing) for any missed sessions, that client failed to give 24 hour notice of cancellation. Client agrees to and hereby authorizes missed session(s) to be billed to their credit card that will be placed on file with therapist.

Acknowledgement:

By signing this below, client acknowledge that he/she has reviewed and fully understands the terms and the conditions of this Agreement. Client agrees to abide by the terms of this agreement.

Patient Name:_____Date:_____

Patient Signature:_____Date:_____