Dr. Irit Goldman, PsyD. MFC46437
Licensed Marriage and Family Therapist
1604 Ford Ave, Suite 1
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Tel: (209)605-9626
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Inform Consent

Client's name ________________________________ Date: _________________

Introduction
This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

Information from Your Therapist
At an appropriate time, your therapist will discuss her professional background with you and provide you with information regarding her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience and professional orientation.

Information About This Practice (as applicable)
The name of this practice is Dr. Irit Goldman PsyD, MFT

Fees and Insurance
PLEASE NOTE THAT I DO NOT ACCEPT CHECKS.

$180.00 per session.

COUPLE THERAPY $20.00 Above individual rate.

Please note, Dr. Goldman does not accept insurance.

Sessions are 50 minutes in length.

If you have unpaid bills, after 30 days, it will be turned over to a collection agency. Be aware that it may affect your credit.

(Over)

Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, your therapist will not disclose information communicated privately to her by one family member to any other family member without written permission.)

Exception to Confidentiality

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment.

If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with her, when working with other members of your family. Please feel free to ask your therapist about her "no secrets" policy and how it may apply to you.

Minors and Confidentiality

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. In order to cancel or reschedule an appointment, **you are expected to notify your therapist at least 24 hrs. in advance of your appointment. If you do not provide your therapist with at least 24 hours notice in advance, you are responsible for payment for the missed session**. Please understand that your insurance company will not pay for missed or cancelled sessions.

Therapist Availability/Emergencies

Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions. Any cancellation exceeding 5 minutes will be charged based on a prorate of your session fees. All letters to the court, or copy and summary of records will be charged based on your session fee.

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You may leave a message for your therapist at any time on her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail.

You may leave a message for your therapist at any time on her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call.

You should be aware that your therapist is generally available to return phone calls within approximately 24 hours. Your therapist is not able to return phone calls after 8:00 PM.

If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail message.

In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Therapist Communications

Your therapist may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

___ My therapist may call me at my home. My home phone number is: (   ) ________________

___ My therapist may call me on my cell phone. My cell phone number is: (   )______________

___ My therapist may send mail to me at my home address.

___ My therapist may send mail to me at my work address.

___ My therapist may communicate with me by email. My email address is __________________

___ My therapist may send a fax to me. My fax number is: (   ) _____________________________

About the Therapy Process

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

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Statement for Contract
Patient acknowledged and understands that Dr. Goldman is a sole-proprietor, which means that she is in the business for herself and that Dr. Goldman is not engaged in a partnership, a joint venture, a professional corporation, or any other form of business organization with any of the other practitioners in this suite of offices.

Termination of Therapy
The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.
You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

If you did not attend therapy for 30 days, your file will be closed, automatically. However, you can always call at a later date to restart your therapy.

Your signature indicates that you have read this agreement for services carefully and understand its contents.

Please ask your therapist to address any questions or concerns that you have about this information before you sign!

_________________________________ ___________________________________
Name of Patient Signature

Date: ___/ ___/ ____

Letter Writing
Should you need me to write a letter on your behalf to any establishment, (i.e., court, disability, etc.) there will be a charge of a full session for letter writing.

By signing this you acknowledge that you are aware of this policy.

____ _________________
Signature Date

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