INFORMED CONSENT
DISCLOSURE STATEMENT & AGREEMENT FOR SERVICES

Tricia Peterson, Licensed Marriage & Family Therapist #44781
441 N. Central Ave., 5A
Campbell, California 95008
(408) 204-4248

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 me (Tricia Peterson, MFT) any questions that you may have regarding its contents.

Information About Your Therapist

At an appropriate time, I will discuss my professional background with you and provide you with information regarding my experience, education, special interests, and professional orientation. You are free to ask questions at any time about my background, experience and professional orientation.

I am a Licensed Marriage & Family Therapist, License # MFT 44781, and operate my private practice under my name.
My fee for service is $140 and sessions are 50 minutes in length.
Please ask about costs associated for preparation for trial and other legally related communications if this is a court involved case.
Fees are payable at the time that services are rendered, unless a prior arrangement is made.

If for some reason you find that you are unable to continue paying for your therapy, you should inform me as soon as possible. I will help you consider other options that may be available to you at the time.

Confidentiality

All communications between you and I 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, I will *not* disclose confidential information about your treatment unless all persons who participated in the treatment with you provide their written authorization to release such information. *However, it is important that you know that I utilize a "no-secrets" policy when conducting family or marital/couples therapy*. This means that if you participate in family, and/or marital/couples therapy, I am permitted to use information obtained in an individual session that you may have had with me when working with other members in your family. Please feel free to ask me about my "no secrets" policy and how it may apply to you. ~Continued on next page.

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Confidentiality cont'd

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. I may also be required or permitted to break confidentiality when I have determined that a patient presents serious danger of physical violence to another person or when a patient is dangerous to him or herself.

Further, we understand that information and records otherwise confidential and/or testimony concerning my family or me **must** be provided in the event of a court order demanding it. Also, in litigation or official proceedings, information and records otherwise confidential and/or testimony concerning my family and I may have to be provided in limited circumstances without my specific consent in accordance with the law.

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, I may, in the exercise of my professional judgment, 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 me.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify me at least 48 hours in advance of your appointment. If you do not provide me with at least 48 hours notice in advance, you are responsible for payment for the missed session. If you have a Monday appointment, you should advise me on Thursday.

Therapist Availability/Emergencies

Telephone consultations between office visits are welcome. However, I will attempt to keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions.

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Therapist Availability/Emergencies

You may leave a message for me at any time on my voicemail. If you wish for me 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 during regular workdays (Monday through Friday) within 24 hours. If you have an urgent need to speak with me, please indicate that fact in your message. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 9-1-1 to request emergency assistance.

Therapist Communication

I 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 me 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 # is: ___________________________________

___ My therapist may call me on my cell phone.
My cell phone # is: _________________________

___ My therapist may call me at work.
My work # is: ____

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

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___ My therapist may communicate with me by email.

My email address is: ____

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About the Therapy Process

It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I 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, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

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 me. I 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 are court ordered for therapy, please discuss this with me first. If you or I determine that you are not benefitting from treatment, either of us may elect to initiate a discussion of your treatment alternatives.
Your signature indicates that you have read this agreement for services carefully and understand its contents.

Please ask me to address any questions or concerns that you have about this information before you sign.

____

Signature (please also print your name)

Signing consent for self or for minor child? Self ____ Child: ____

Child's Name ____

Date: _____________________