AGREEMENT FOR SERVICE / INFORMED CONSENT

This Agreement is intended to provide you with important information regarding my practices, policies, and procedures and to clarify the terms of the professional therapeutic relationship. Please speak with me if you have any questions or concerns regarding the contents of this Agreement.

LICENSURE:
I am self-employed and operate a private practice. I am licensed by the California Board of Behavioral Sciences as a Marriage and Family Therapist (LMFT 48949). The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of Marriage and Family Therapists. To file a complaint, you may contact the Board online at www.bbs.ca.gov or by calling (916) 574-7830.

COUNSELING SESSIONS:
The initial Discernment Counseling session is a 2 hour session and the fee is $280. Each additional Discernment Counseling session is 1 ½ hours and the fee is $210.

CONFIDENTIALITY:
Information disclosed is strictly confidential and will not be released to any third party Information disclosed is strictly confidential and will not be released to any third party without written authorization, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, reporting child, elder, and dependent adult abuse, when a client makes a serious threat of violence towards a reasonably identifiable person and/or their property, or when a client is dangerous to him/herself. Additionally, there are a few situations which require me to make a child abuse report that many people are unaware of: 1) Certain situations in which domestic violence occurs in the presence of a child, 2) Viewing sexually obscene pictures of children, and 3) Certain consensual sexual activities among and with minors.

I use cellular phones and e-mail to communicate with clients. There is a potential that these electronic communication methods could be accessed by unauthorized people, which limits the privacy and confidentiality of such communication.

I maintain client confidentiality by not greeting clients in public unless they first acknowledge me and by not connecting with past or present clients on social networking websites.

PSYCHOTHERAPIST-CLIENT PRIVILEGE:
Information disclosed during the counseling process, as well as any records created, is subject to the psychotherapist-client privilege. The psychotherapist-client privilege results from the special relationship between the therapist and the client in the eyes of the law. It is similar to the attorney-client or doctor-patient privilege. Typically, the client is

the holder of the psychotherapist-client privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-client privilege on your behalf until instructed, in writing, to do otherwise by a person with the authority to waive the privilege on your behalf. Any concerns regarding the psychotherapist-client privilege, should be discussed with your attorney.

RECORDS AND RECORDKEEPING:

I often take notes during sessions, and I will also produce other notes and records regarding your treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Should you request a copy of these records, you must make this request in writing. I reserve the right, under California law, to provide a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the records under certain circumstances, but may, as requested, provide a copy of the records to another treating healthcare provider. I will maintain your records for a minimum of 10 years following the termination of therapy. However, after 10 years, your records may be destroyed in a manner that preserves your confidentiality.

RISKS AND BENEFITS OF THERAPY:

Psychotherapy is a process in which you and I will discuss many different events, experiences, and memories for the purpose of creating positive change, so you can experience life more fully. It may result in a number of benefits, including but not limited to, reduced stress and anxiety, a decrease in negative thoughts and unhelpful behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require a substantial effort on your part, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts, and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participation in therapy may involve some discomfort, including remembering and discussing unpleasant events, feelings, and experiences that could evoke strong feelings of sadness, anger, fear, etc. There may be times that I will challenge your perceptions, assumptions, and perspectives. The issues that you present in therapy may result in unintended outcomes, including changes in personal relationships. Decisions you make about the status of your personal relationships are your responsibility.

During the therapeutic process, you may feel worse before you feel better. Personal growth and change may be easy and swift at times but may also be slow and frustrating. Please address any concerns regarding the therapy process with me.

VOICEMAIL AND EMERGENCIES:

You may leave me a voicemail message at any time. I will make every effort to return your call by the next business day. I have found that working on issues in person is more

effective than trying to resolve issues by phone. Therefore, telephone conversations should generally be used for arranging appointment times and emergencies only. In case of an emergency, in which you are feeling unsafe or require immediate medical or psychiatric assistance, you should call 911 or go to the nearest emergency room.

CONSULTATION WITH OTHER PROFESSIONALS:

I may seek assistance from professional colleagues regarding your treatment by speaking to them about your therapy sessions. When this occurs, I will ensure that your identifying information is thoroughly disguised.

TELEHEALTH SESSIONS:

On a case-by-case basis, I conduct sessions online using a secure, HIPAA compliant, video conferencing system called Doxy.me. To conduct sessions online, you and I must both agree that conducting sessions online would be helpful in your particular case. Your agreement to conduct sessions online represents your consent to utilize this format. The benefits of conducting sessions online include the ability to meet when it is not practical or possible for one or both of us to meet in person. The risks of conducting sessions online include the possibility that confidentiality could in some way be compromised as well as the possibility that one or both of us could miss or misinterpret something during the session, such as facial expressions. If a video session suddenly disconnects, I will always call your cell phone to troubleshoot the problem. If you experience an emergency during the session, please call 911 to contact your local emergency services.

PAYMENT, FEES, AND CANCELLATION POLICY:

Payment is due when the service is rendered. Fees for additional services such as extended phone conversations, consultations with others (physicians, family members, etc.), inpatient hospital visits, etc., will be based on the nature and extent of the service in accordance with my session rate. This will be discussed with you prior to the service.

You will be charged your full session fee for sessions cancelled with less than 24 hours' notice and for any sessions that you miss. To cancel an appointment, you may either email me or leave a message on my voicemail at any time, day or night, and it will record the date and time of your call. There is a $32.00 charge for any returned check.

SUBMITTING TO PPO INSURANCE:

If you decide to submit your session receipts to an insurance company for reimbursement, please note that your insurance company may request to review your treatment and treatment records.

TERMINATION OF THERAPY:

You and I both have the right to terminate therapy at any time. Reasons that I may decide to end your sessions include, but are not limited to, your failure to comply with

treatment recommendations, conflicts of interest, your failure to participate in therapy, your needs are outside of my scope of competence or practice, you are not making sufficient progress in therapy, or untimely payment of fees. In these situations, I will attempt to ensure a smooth transition to another therapist by offering referrals.

ACKNOWLEDGEMENT:

By my signature below, I certify that I understand the information contained in this document. I agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy. Moreover, I agree to hold Brian Whitley, LMFT free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from treatment. I have been offered a copy of this document for my own records.

Date_____

Client Name (Please Print)_____

Client Signature_____

Client Name (Please Print)_____

Client Signature_____