INFORMED CONSENT FOR COUPLES PSYCHOLOGICAL SERVICES

_____	_____	_____	_____
Last Name	First Name	Middle Initial	Record#
_____	_____	_____	_____
Last Name	First Name	Middle Initial	Record#

I

Welcome: Let me take this opportunity to welcome you personally to my office and to your initial consultation. I look forward to working with you as a couple and learning about you and your concerns. My hope is that throughout this journey you gain life changing insight and experience personal growth that will serve you for the rest of your married life. Please understand that your success in treatment is highly dependent upon your goals, needs, and motivation to improve your life circumstances. It is my hope that we will work together in partnership to help you focus on and address the issues that are most important for you. At times, our partnership may involve discussing painful or difficult aspects of your life, and you may experience unpleasant or uncomfortable emotions such as sadness, anger, guilt/shame, hopelessness, or frustration. These are all normal emotional reactions, and I am trained to help you effectively work through them so that you may experience personal growth. Congratulations on having the courage to invest in your marriage!

II

I am required by law to review with you my policies, business practices, and your rights as a client, the couple. Please read this consent form thoroughly and in its entirety. I will review this form with you and will answer any questions you may have. This informed consent document is a precursor to treat, and we will not be able to begin our work together until this document has been read, reviewed, and signed.

_____**CONFIDENTIALITY:** I am required to ensure that what is discussed in your session will remain between us. However, according to California law, the following are exceptions:

1. I am a mandated reporter. This means that if there is suspected child, elder, or dependent adult abuse, I am legally required to report this information to the proper authorities. I am not required to inform you before reporting; however, you will be informed of any needed reporting as a courtesy.
2. If I believe that there is serious threat of harm to an identified victim, then I must inform the police as well as the identified potential victim.
3. If I believe that you are in danger of harming yourself or you are unable to care for yourself, I must inform the proper authorities.

4. If you choose to involve your insurance company for billing such as filing a claim, insurance audits, case review, or appeals.
5. If I receive a signed subpoena from the court, I will comply with the order. However, I will contact you to alert you. **If you are involved in a matter of litigation and are asked to sign a release of confidential information form, please consult with an attorney before signing away your right to confidentiality.**
6. **In couple's therapy, I will NOT under any circumstances keep secrets from your significant other.**
7. If fees are delinquent, the minimum info necessary about your treatment may be referred to a collection's agency.

_____**PROFESSIONAL CONSULTATION:** Professional consultation is an important aspect of a healthy psychotherapy practice. Therefore, it is important for you to know that I regularly participate in clinical, ethical, and legal consultation with appropriate professionals regarding my cases. During these consultations, I will not reveal and personally identifying information regarding you or those associate with you.

_____**RECORDS AND RECORD KEEPING:** There may be instances over the course of treatment that may require me to take notes during the session. These notes constitute clinical and business records, which I am required to maintain according to the law. These records are the sole property of TARA NYASIO, Psy.D., A PSYCHOLOGICAL CORPORATION. Neither the record nor my record keeping process will be altered at the request of any client. Any request(s) for a copy of my records should be made in writing. Under California law, I reserve the right to provide a treatment summary in lieu of actual records. Under California law, I also reserve the right to refuse to produce a copy of the record if so doing would be harmful but will provide a copy of the record to another treating health care provider is the request is accompanied by a signed release of information. I will maintain your records for seven years following the termination of therapy. After seven years, your records will be destroyed and will no longer be available for review.

_____**FEES/PAYMENTS:** Initial consultations are 60-minutes and are priced at **$100.00**. Subsequent sessions are 60-minutes, and the cost of the subsequent session is **$200.00**. Telephone sessions are not available for couples therapy. If you decide to divorce and wish to reveal any information from couples treatment, please be advised that I will decline to speak on either of your behalf since both partners are equal members of the couple. Therefore, I must always maintain neutrality and, am, therefore, unable to testify on any partner's behalf against the other.

If you choose to use your insurance to cover the costs of psychological treatment, I will bill it as a courtesy. If I am not an authorized provider in your insurance network, you will be responsible for full fee payment for each session. However, you may still bill your insurance for out-of-network services. I will provide a superbill that you may then submit to your insurance carrier. However, please note that couple's therapy is often not covered by insurance. Regardless of your payment choice, payment (co-payment or full fee) is due at the beginning of each session. Preferred payment methods include credit and debit cards and cash.

To run an efficient practice, you will be requested to provide a valid cred card to keep on file. You may elect to satisfy any full fee payments using the card on file. Carrying a balance of more than one session is not permitted. Payment is due at the beginning of each session. Services cannot continue until any delinquent amounts have been cleared. If your account has not been paid for more than 60 days, I reserve the right to use legal means to secure payment.

_____**CANCELLATION AND NO-SHOW POLICY:** Your time slot is protected and will not be offered to another client who is seeking services. Therefore, 24-hours' notice is required for cancellations of appointments. You will be assessed a full fee penalty of **$200.00**, **charged to the credit card on file**, in the event of a no-show/late cancellation appointment. Please be aware that your insurance plan will not cover no-show/late cancellation fee. **This cost will be paid solely by you**.

_____**AVAILABILITY:** I am available for regularly scheduled appointment times. Vacations, jury duty summons, and planned sick days will made available when possible. You will be contacted and may be provided the name of another therapist on call. Messages for me may be left at 657-267-7521. You may leave a message at any time on the confidential voicemail. I do not have an afterhours call service. Non-urgent calls will be returned with 24-hours during normal business hours. Please remember to speak clearly and leave your 10-digit call back number in your message. In the event of a life-threatening mental health emergency, PLEASE DO NOT CALL the office. Please dial 9-1-1 or go to the nearest emergency room.

_____**TERMINATION OF TREATMENT:** You have the right to refuse or discontinue services at any time. Additionally, you may be terminated from treatment if payments are not made, if there is nonadherence to treatment recommendations, or if sessions are not attended sober. You may be referred to another therapist if, during treatment, another problem emerges that is outside of the scope of my practice.

III

INFORMED CONSENT SIGNATURE PAGE

This agreement constitutes the entirety of our professional contract. I have the right to keep a copy of this contract if requested. My signature below also confirms that I have read and understand the information in this document. My signature constitutes my agreement and compliance to this document during our professional relationship.

I hereby give my permission to Tara Nyasio, Psy.D., A PSYCHOLOGICAL CORPORATION conduct an evaluation and/or provide treatment.

_____	_____	_____
Client's Name	Client's Signature	Date
_____	_____	_____
Client's Name	Client's Signature	Date
_____	_____	_____
Provider's Name	Provider's Signature	Date

AGREEMENT FOR THIRD PARTY REIMBURSEMENT:

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I must provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. 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. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit, if you request it. ***You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.***

Please mark your selection.

☐ I understand, and I do **NOT** agree to utilize my insurance benefits.	☐ I understand, and I agree to utilize my insurance benefits.
Please complete Section A	Please complete Section B

Section A:

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY:

_____ I hereby agree to bear financial responsibility to Tara Nyasio, Psy.D., A PSYCHOLOGICAL CORPORATION for the full fee of my psychological treatment.

Section B:

AUTHORIZATION OF RELEASE OF INFORMATION:

_____ I hereby authorize Tara Nyasio, Psy.D., A PSYCHOLOGICAL CORPORATION to (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of evaluation and/or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims.

ASIGNEMNT OF BENEFITS:

_____ I hereby authorize my insurance carrier(s), to issue payments directly to Tara Nyasio, Psy.D., A PSYCHOLOGICAL CORPORATION for mental health services rendered to myself and/or my partner.

THIRD PARTY REIMBURSEMENT SIGNATURE PAGE

_____	_____	_____
Client's Name	Client's Signature	Date
_____	_____	_____
Provider's Name	Provider's Signature	Date