Informed Consent for Cognitive Behavioral Therapy, Assessment/Evaluation or Psychotherapeutic Consultation (Individual, Couple, Group, and Family)

The state expects that you will be informed of all possible contingencies that might arise in the course of psychotherapy. Please check to be sure you have read, understood, and discussed all questions with your therapist. An informed consent has the force of contract, so we cannot proceed until we reach an agreement on all items. FEE____________________

Name _________________________________Date of Birth ______________________

Name _________________________________Date of Birth ______________________

Address ____

City _____________________ Zip Code __________ Phone ___________________

Mailing Address (If different): ____

Social Security # ____________________ Driver's License # ____________________

Business Address ____

Business Phone ____________________

Referred by: ____

Medical Insurance ____

Insured's Name (If different) ____

Policy Number _____________________________ Group Number ______________

Note on Cancellations: Due to the nature of my practice, I must hold you responsible for all regularly scheduled consultation sessions *whether or not you are able to attend*. Should it be necessary for you to cancel an appointment, I must have 24 hours notice in order to waive the fee. I cannot bill your insurance for missed sessions.

Note on Insurance Reimbursement: Due to the complexities and time delays of insurance reimbursements, I must ask that you pay your Co-Pay or full payment if not covered by insurance at the beginning of each session. When possible, I will bill your insurance company, but please understand that I am not on all insurance panels and some psychological procedures, such as pre-surgery evaluations and psychological testing are not normally covered by most insurance plans.

Confidentiality: State law and professional ethics require therapists to maintain confidentiality except for the following situations:

1. If there is suspected child abuse, elder abuse, or dependent adult abuse.
2. "Tarasoff" or "Ewing" situations in which serious threat to a reasonably well- identified victim is communicated to the therapist.
3. When threat to injure or kill oneself is communicated to the therapist.
4. If you are required to sign a release of confidential information by your medical insurance.

5. If you are required to sign a release for psychotherapy records if you are involved in litigation or other matters with private or public agencies. Think carefully and consult with an attorney before you sign away your rights. We can discuss some foreseeable possibilities together.

6. Clients being seen in couple, family, and group work are obligated legally to respect the confidentiality of others. The therapist will exercise discretion (but cannot promise absolute confidentiality) when disclosing private information to other participants in the treatment process. Secrets cannot be kept by the therapist from others involved in your treatment process.

7. I may at times speak with professional colleagues about our work without asking permission, but all identities will be disguised.

8. My personal secretary and office manager have access to locked and coded records but are legally charged with confidentiality.

9. Clients under 18 do not have full confidentiality from their parents.

10. It is also important to be aware of other potential limits to confidentiality that include the following:

- All records as well as notes on sessions and phone calls can be subject to court subpoena under certain extreme circumstances. Most records are stored in locked files but some are stored in secured electronic devices.
- Cell phones, portable phones, faxes and e-mails are used on some occasions.

- All electronic communication compromises confidentiality.

About the Relationship with the Therapist

Because of the nature of psychotherapy, the therapeutic relationship has to be different from most relationships. It may differ in how long it lasts, in the topics we discuss, or in the goals of our relationship. It must also be limited to the relationship of therapist and client only. If we were to interact in any other ways, we would then have a "dual relationship". Therapy professions have rules against such relationships to protect us both.

- I cannot be your supervisor, teacher, or evaluator.
- I cannot be a therapist to my own relatives, friends (or the relatives of friends), people I know socially, or business contacts. I cannot have any other kind of business relationship with you besides the therapy itself.
- I cannot give legal, medical, financial, or any other type of professional advice.
- I cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client.

There are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions. A therapist offers you choices and helps you consider what is best for you.

You should also know that therapists are required to keep the identity of their clients confidential. Therefore, if you have any particular preferences about public meetings, let me know, otherwise I may ignore you when we encounter each other in a public place. I must decline to attend your family's gatherings if you invite me. Lastly, when therapy is completed, I will not be able to socialize with you like your other friends. In sum, my duty as therapist is to care for you and my other clients, but only in the professional role of therapist. I am not permitted to give or to receive gifts from clients except tokens with personal meaning to the therapy process.

Fees: The fee for service generally covers a 45-minute session and will be agreed upon in the first treatment session and payable at the time service is rendered. Telephone calls may be charged at approximately the same rate as personal consultation plus any telephone company charges.

Availability: The therapist is available for regularly scheduled appointment times. Dates of vacations and other exceptions will be given out in advance if possible. Telephone appointment times can be made by calling the office during regular office hours.

Emergency numbers where the therapist can sometimes be reached: (909) 229-1253

Emergency service can be obtained at:

Riverside County Emergency Treatment Services

9990 County Farm Road, Ste 4

Riverside, CA 92503

(951) 358-4881 /82 /83

Termination of Treatment: The therapist may terminate treatment if payment is not timely, if prescriptions are not filled (such as seeking consultation, refraining from dangerous practices, coming to sessions sober, etc.), or if some problem emerges that is not within the scope of competence of the therapist or if the therapist experiences the interaction as abusive. Clients have the right to terminate at any time, but the usual minimal termination for an ongoing treatment process is one-to-two sessions.

Clients are urged to consider the risks that major psychological transformation may have on current relationships and the possible need for psychiatric consultation during periods of extreme depression or agitation. Not all people experience improvement from psychotherapy and therapy may be emotionally painful at times. For information on other kinds of treatment in our community call California State Board of Psychology. Patients have the right to refuse or to discontinue services at any time and complaints can be addressed to:

California State Board of Psychology
1422 Howe Avenue, Suite 22
Sacramento, California 95825-3200
(916) 263-2699

General Information about My Approach. Although cognitive therapy and cognitive behavioral therapy interventions are the primary techniques I will use to help you make changes in your life, I will work with you in a flexible and comprehensive manner to best meet your needs. For instance, it is often assumed that past experiences are not addressed in cognitive therapy. I believe that depending upon one's individual circumstances, it may be important to examine past events and relationships in order to understand how they may be currently impacting one's life. In addition, if indicated, I will discuss with you the possibility of supplementing your treatment with medication. I will provide referrals to experienced psychopharmacologists and work closely with the professional that you choose.

Agreement for Psychotherapy and or Consultation

I have read this informed consent completely and have raised any questions I might have about it with my therapist. I have received full and satisfactory response and agree to the provisions freely and without reservations.

I understand that my therapist is responsible for maintaining all professional standards set forth in the ethical principles of his/her professional association as well as the laws of the state of California governing the practice of psychotherapy and that he/she is liable for infractions of those standards.

I understand that I will be fully responsible for any and all legal and/or collection costs arising as a result of my contact with my therapist, including compensation at our agreed upon rate for his or her time involved in preparing for and doing court work.

I understand that my therapist from time to time makes teaching and research contributions using disguised client material. By consenting to treatment I am giving consent to this process of professional contribution and the right to use disguised material without financial remuneration.

Arbitration Agreement

I agree to address any grievances I may have directly with my therapist immediately. If we cannot settle the matter between us, then a jointly agreed-upon outside consultation will be sought. If not, an arbitration process will be initiated under the auspices of the American Arbitration Association, which will be considered as a complete resolution and legally binding decision under state law, which [in California] states us follows:

"NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE

GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE ONE OF THIS CONTRACT."

Article 1: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." Any arbitration process will be considered as a complete resolution and legally binding decision. The client will be responsible for the costs of this process. In agreeing to treatment, you are consenting to the above identified grievance procedures.

This agreement constitutes the entirety of our professional contract. Any changes must be signed by both parties. I have a right to keep a copy of this contract.

______________________________ ____________________
Client Signature Date

______________________________ ____________________
Client Signature Date

______________________________ ____________________
Therapist Signature Date

______________________________ ____________________
Legal Parent or Guardian Signature Date

Statement of the Therapist

This document was discussed with the client and questions regarding fees, diagnosis, and treatment plan were discussed. I have assessed the client's mental capacity and found the client capable of giving an informed consent at this time.

Date and Initial of Therapist ____.

Michael C. Walker Psy.D
5790 Magnolia Ave. Suite 202
Riverside, CA 92506
909-229-1253

Consent to Use or Disclose Information for Treatment, Payment, and Healthcare Operations (TPO)

Federal regulations (HIPAA) allow me to use or disclose Personal Health Information (PHI) from your records in order to provide treatment to you, to obtain payment for services I provide, and for other professional activities (known as "healthcare operations"). Nevertheless, I ask your consent in order to make this permission explicit. The notice of privacy's practice describes in these disclosures more detail. You have a right to review The Notice of Privacy Practices before signing this document. I reserve the right to revise The Notice of Privacy Practices at any time. If I do so, the revised notice will be posted in the office. You may ask for a printed copy of the notice at any time.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or healthcare operations; however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary. You may refuse to sign it. However, I am permitted to refuse to provide healthcare services if this consent is not granted or if the consent is later revoked.

I hereby consent to use or disclose my personal health information as specified above.

____

Signature of client Date Name of Client

I acknowledge that the HIPAA Notice of Privacy Practices is posted in this office and a copy will be available for my personal use should I request.

____

Signature of client

Release of Protected Health Information (PHI)

Name of Client: ____

Date of Birth: ____

I hereby authorize the release and exchange of information between Michael C. Walker, Psy.D and the following health care professional, agency, or institution:

Health Care Professional: ____

Address: ____

Phone Number: ____

This authority extends to the furnishing of copies of all or any desired portions of the records pertaining to the above named client.

Michael C. Walker, Psy.D and the individual, agency, or institution named above are hereby released from all legal liability that may arise from this exchange or release of information.

This Release will remain in effect until:________________________________.

I understand that I may revoke this consent at any time by informing all of the above parties in writing.

Signature ____Date ________________
Patient

Signature ____Date ________________
Parent or Guardian

Note: The 1996 Federal Health Information Portability and Accountability Act (HIPAA) allows with one generic release the exchange of Protected Health Information (PHI) involved in **t**reatment, **p**ayment, and health care **o**perations (TPO). Patients may request restrictions on this exchange and revoke it at any time (in writing).

Initial Psychological Visit Questionnaire

Please take a few minutes to answer these questions. This will give us more time during your session and provide me a greater understanding of your circumstances. If you are uncomfortable with any of these questions please leave those questions blank and will discuss them during your session.

Name: ____

Education: ____

Occupation: ____

Currently working: ____

Time on the Job:____

Military service: Yes____ No____

If yes: Active_____ Reserve_____ Discharged/retired______

Relationship Status:

Single____ Married_____ Divorced____ Widowed___ Cohabitating

Children: Yes____ No____

If yes:

Number of children:______

Custody: Living with you____ Shared custody_____

Age(s):____

Gender:____

Living___ Deceased____

Children with special needs or chronic illness?

____

____

Have you ever been in psychotherapy before? Yes____ No____

If yes, when? ____

May I contact your previous therapist(s)? ___________________________________

Family History of psychological distress? Yes____ No_____

Depression_______ Anxiety______ Suicide_______ Substance abuse______

Other___________________________

Health Issues:

Family doctor:_________________________________ Phone Number____________

Last office visit:______________________________

Please list all hospitalizations and operations. Give diagnoses and dates:

____

____

____**Have you ever suffered from any of the following illnesses?**

	NO	YES	DATE OF ONSET
Cancer	___	___	_________
TB	___	___	_________
Diabetes	___	___	_________
Thyroid trouble	___	___	_________
Kidney trouble	___	___	_________
High blood pressure	___	___	_________
Eye trouble	___	___	_________
Heart trouble	___	___	_________
Neurological disease	___	___	_________
Ulcers	___	___	_________

Head injury	___	___	________
D.T.'s	___	___	________
Allergies	___	___	________

List all allergies: ____

____Any

other serious illnesses? ____

____

Medical Symptoms

Check any of the following symptoms that apply to you at this time. Also indicate when any of these symptoms have applied to you in the past.

Hair falling out	_______	Fainting spells	________
Weight gain	_______	Difficulty sleeping	________
Fatigue	_______	Drinking too much fluid	________
Constipation	_______	Blurred vision	________
Dry skin	_______	Deafness	________
Weakness	_______	Ringing in ears	________
Weight loss	_______	Chest pain	________
Tremor	_______	Shortness of breath	________
Big appetite	_______	Tingling of hands or feet	________
Fast heart beat	_______	Ankle swelling	________
Diarrhea	_______	Indigestion	________
Poor appetite	_______	Nausea or vomiting	________
Headaches	_______	Urinary difficulties	________
Dizziness	_______	Problems with sexual organs	________

Drug/Medication History

Because many drugs (legal and illegal) have psychological effects, it is important for me to know what drugs you are *currently* taking and/or *have taken in the past*. This information will remain strictly confidential, but it is very important for me to know before you begin therapy so that an accurate assessment of your problem and situation can be made. Please list *all* legally prescribed, over the counter, herbal supplements and illegal drugs ever used (past or present).

Prescription Medications: Name, Dose, Prescribing doctor P=Past C=Currently

____

____

____

____

Illegal Drugs:

____

____

____

____

Herbal supplements:

____

____

____

Alcohol: None____ Dailey____ Weeky_____ Monthly_____ Other_____

Tabacco: Yes______ No________

Cafeein: Yes______ No________

Have you ever been on worker's comp or disability? For what, how long, results?

____

____

____

____

Which of the items below best describes the issue(s) you want to work on in therapy?

Relationship/Marriage ☐

Family Relationships ☐

Work/School ☐

Legal ☐

Trauma ☐

Eating/Weight ☐

Abuse: Physical/Sexual ☐

Children/Parenting ☐

Grief ☐

Financial ☐

Substance Abuse ☐

Physical Health ☐

Mood (anxiety/depression) ☐

Other ☐

Thank You !