Eva Ghioni ~ Licensed Marriage and Family Therapist # 33567

1221 Pleasant Grove Blvd, Suite 150, Roseville Ca 95678 (916) 995-3166

INFORMED CONSENT

This Agreement is intended to provide you with important information regarding the practices, polices and procedures of therapy and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Benefits and Risks of Therapy

Psychotherapy is a process in which Therapist and Patient discuss a myriad of issues, events, experiences and memories, for the purpose of creating positive change, so Patient can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Patient may be experiencing. Such benefits require the Patient to take on an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. Psychotherapy is a joint effort between Patient and Therapist. There is no guarantee that therapy will yield any, or all of the benefits Patient desires. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Patient's perceptions and assumptions, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationships is the responsibility of Patient.

During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Remember, change does not happen over night. You have spent many years developing the patterns and beliefs that have gotten you to this point, and it will take time to learn and practice new ways of being in your life that work better for you. Patient should address any concerns he/she has regarding his/her progress in therapy with Therapist.

One of the most important things about therapy is that it is a good fit for both the Patient and the therapist. The first few sessions are an assessment period to determine treatment needs, and if the Therapist can best meet the needs of the Patient. It is also a time for the Patient to decide if the Therapist is a good fit for the Patient.

Confidentiality

The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, 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 patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.

Please note, if you desire to send or receive email's or texts with this Therapist, you acknowledge that I cannot guarantee there security, but will do my part to protect your confidentiality. _____Please initial here if you understand the risks of communicating with me via electronic means, and still wish to do so. Your initials indicate you understand the risk, and consent to the communication with your counselor electronically.

Patient Litigation

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient and another individual, or entity, are parties. Therapist has a policy of not communicating with Patient's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Patient agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at a rate of $300.00 per hour, and a required $1000.00 retainer to be collected prior to any work performed on your behalf with/for the legal system.

Fee and Fee Arrangements

The usual and customary fee for service is $_____ per 50 minute session. Sessions longer than 50-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Patient will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by agreement with Therapist. Phone calls to you (or third parties requested by you) lasting longer than 10 minutes, will be charged my regular hourly fee (pro rata).

Patients are expected to pay for service's at the time service's are rendered. Therapist accepts cash, checks, and major credit cards. **You must fill in and sign the Credit Card Authorization form**, even if you are paying by cash or check, to authorize charges for any late cancellations, missed appointments, or returned checks. If checks are returned, you will be charged the amount of the returned check, as well as the fee's my bank charges me for returning your check.

Cancellation Policy

Patient is responsible for payment of the agreed upon fee for any missed session(s). Patient is also responsible for payment of the agreed upon fee for any session(s) for which Patient failed to give Therapist at least 24 hours notice of cancellation. Cancellation notice should be left on Therapist's voice mail, or texted to me at 916-995-3166

Therapist Availability

Therapist's office is equipped with a confidential voice mail system that allows Patient to leave a message at any time. Therapist will make every effort to return calls within 24 hours, on business days, but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

Termination of Therapy

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, **but are not limited to,** untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest (which due to confidentiality, therapist may not be able to discuss what the conflict is with patient), failure to participate in therapy, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion.

Acknowledgement

By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Patient agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

In order to provide continuity of care, I may need to contact you physician to coordinate treatment. My Doctors Name, Phone #, and Address is:_____

_____

Patient Name (please print)_____

Signature of Patient)_____ Date_____

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

Credit Card Authorization:

Please complete this form even if you will not be charging your sessions on a regular basis. Missed appointments and returned checks will automatically be charged to this credit account.

Client Name:_____

Name as it appears on Credit Card:_____

Your Billing Zip Code:_____

Billing Address:_____

Credit Card Type:(circle one)

Visa Master Card Discover American Express

Credit Card Number:_____

Expiration Date:_____

CCV (3 digit code on back): _____

Please Check One of the Two Options:

_____I authorize Eva Ghioni to process my credit card for payment of service's on a recurring basis for all scheduled appointments including missed appointments, late cancellations, and returned checks.

_____I authorize Eva Ghioni to process my credit card for payment of returned checks, missed appointments, late cancellations and visits for which I do not pay by cash or check.

Signature_____ Date_____