Alexandra Laifer, Ph.D.
Clinical Psychologist

Helping You Achieve Personal Growth & Well-Being

CLIENT AGREEMENT FORM

Status of Therapist: Alexandra Laifer, Ph.D., is a licensed clinical psychologist (PSY 25307).

During your first session, Dr. Laifer will discuss several important issues with you. This form will help acquaint you with the nature of our services. Please ask for clarification of any issue that may concern you. ***Please initial each blank space if you understand and agree with what is stated.***

CONFIDENTIALITY: In accordance with California law, the information disclosed by you in therapy is confidential and is not released or accessible to anyone else without your written permission. By law, the following exceptions apply and may require relevant information is given to others: (1) danger to self, (2) danger to others, (3) when a child, disabled person, or elderly person is physically abused, sexually abused, or neglected, (4) when a court of law issues a legitimate subpoena, (5) for the purposes of insurance reimbursement, and (6) when a collection service is required for unpaid bills.

_____I acknowledge that I have received a copy of the Health Insurance Portability & Accountability Act (HIPAA) Notice of Privacy Practices, which informs me of my rights regarding Protected Health Information (PHI).

_____I acknowledge that I have received a copy of the Office Policies, Consent for Psychotherapy Services and Social Media Policies and agree to treatment and to abide by the policies to the best of my ability.

_____I understand that my therapist may discuss my case in a confidential manner for the purposes of clinical consultation.

In Case of Emergencies: Please call Dr. Laifer at 760-814-9925. If you are unable to reach Dr. Laifer directly, please call 911 or the San Diego Access and Crisis line at 1-888-724-7240 or go to your nearest emergency department.

PAYMENT OF SERVICES: Please read and initial each of the following:

_____I agree to pay in full for services rendered by Dr. Laifer. I give consent for Dr. Laifer to bill my insurance (if using) and understand that I am responsible for any bills that insurance does not reimburse.

_____I understand that Dr. Laifer's full fee is $200 per 50 minute session, $310 per 80 minute session, and that extended sessions or non-emergency phone therapy will incur an additional prorated fee. The fee that I am responsible for is $_____

_____I understand that cancellations of therapy appointments must be made at least 24 hours in advance and that I will be charged 100% of the agreed-upon fee for missed appointments or cancellations less than 24 hours in advance.

_____I understand that any uncollected bills for services or missed appointments may result in disclosure of my name, telephone number, SSN, and address to a collection agency or small claims court.

_____I understand that payment may be made via cash, credit card, or a check made out to: Alexandra Laifer, Ph.D.

Treatment Outcome: There are no guarantees that treatment will be successful, although most clients do make significant progress. The length and outcome of treatment is based upon your motivation for treatment, how long you have had the symptoms, the skill of the therapist, and other factors.

I (WE) HAVE READ AND UNDERSTAND THE INFORMATION ON THIS PAGE AND HAVE RECEIVED A COPY OF THE HIPAA NOTICE. I (CLIENT) WILL REQUEST A COPY OF THIS ADVISEMENT FORM IF SO DESIRED.

_____	_____	_____	_____
Signature of Client (or parent of minor)	Date	Signature of Therapist	Date