Dr. Stephanie King
Licensed Psychologist PSY 28314
405 Enfrente Rd. Ste. 220
Novato, CA 94945
(415) 827-5446

CONSENT TO TREATMENT AND RELEASE OF INFORMATION

Welcome: Before starting your therapy, it is important to know what to expect, and to understand your rights as well as commitments. This consent form is an attempt to be transparent with you about the therapy process, so you are fully informed prior to starting.

Psychotherapy: Psychotherapy has been shown to be an effective means of helping people in distress. While results vary from person to person, the benefits can include learning to manage and understand emotions and coming to a greater understanding and awareness of yourself and your relationships. While you are likely to benefit from therapy in the long run, it can be difficult and painful at times, especially as powerful or unexpected feelings arise or as you face unpleasant aspects of yourself or your life. Psychotherapy is a joint effort with your therapist that requires time, commitment and active participation. Progress and the length of treatment depend on many factors including the therapeutic relationship, motivation, life circumstances, and the nature and severity of the problems at hand.

Psychotherapy Fees: Session fees are based on a 50-minute session, unless prior arrangements are made. Longer sessions are prorated for extra time. Full payment by cash, check or Visa/Mastercard is due at the start of each session. You may also pay monthly at the first session of the month. In the event that outside contact, such as ongoing phone calls or extensive emails become part of the *regular* treatment, there will be an additional prorated fee.

In addition, due to cost of living increases, I raise my rates each calendar year in March, and in January will begin reminding you of this.

Payment: I accept check, cash or Visa/Mastercard. If paying by Visa/Mastercard, there is a 3% fee increase.

Cancellation Policy: I hold your spot for you and only you each week. Because of this, I require a 48-hour notice for the first three (3) sessions missed during the calendar year. If you cancel with less than 48 hours but more than 24 hours notice and we can reschedule within that same business week you will not be charged for the missed session. If you cancel with less than 24 hours notice, we may still

reschedule but you will be a charged for both sessions, the missed session and the rescheduled session. In addition, if you miss more than three (3) sessions in the calendar year, you will still be charged your usual fee, even if you cancel your session with 48 hours' notice. Additionally, any time I take off from treatment (usually 2-4 weeks per year) you of course, will not be charged. Because I prefer that you receive treatment for the time you have paid me, I will make every effort to find a time to reschedule your appointment, but keep in mind my schedule may be full.

*A special note about cancellations for Medicare patients. If you need to cancel a session within the 24-hour parameters, you will be responsible for cash payment of the missed session based on my current hourly rate.

Late Fees: A 15% late feel will be included to any payment that is 30 days past due unless otherwise discussed.

Insurance: Currently the only insurance I accept is Medicare. However, some insurance companies may reimburse part of your therapy expenses if you have coverage for out-of-network psychotherapy. Upon request, I am happy to provide you with a receipt that you can file with your health insurance provider. Out-of-network reimbursement is often contingent on receiving a medical diagnosis and certain medical diagnosis may not qualify. I do not accept responsibility for collecting payment from your insurance company and cannot guarantee that you will be reimbursed or that you will qualify for a reimbursable diagnosis. Please contact your insurance provider to find out if you have out-of-network coverage.

Confidentiality: It is important that you feel safe to talk about feelings, thoughts, and events in your life. To make this easier, the information you share with me is considered confidential and is protected. All consultations and records are therefore strictly confidential, except under the following circumstances:

- If during your therapy you were deemed to pose a threat of harm to someone else or to yourself.
- If you talk about events that lead me to believe that a child under the age of 18 or an elderly or disabled person is at risk of emotional, physical or sexual abuse, neglect or exploitation.
- If you are not yet 18 years of age, your parents or legal guardians may have access to your records and may authorize release of information to other parties on your behalf.
- If you disclose sexual misconduct by a previous therapist I am required to make a report to the licensing board governing the license of the therapist.

- If a judge in a court of law orders me to release information or if I need to respond to a lawfully issued subpoena.

Release of Information: From time to time, I may consult with other mental health professionals regarding your treatment. By signing below, you agree to release information regarding our treatment for the express purpose of consultation. Such consultation will never include any of your identifying information, except when it is absolutely necessary (i.e. with a psychiatrist or other medical doctor).

Social Media Policy: I do not accept friend or contact requests from current or former clients on any social networking sites (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

The Scope of My Services: I am qualified to work with a wide variety of patients and problems, but sometimes I may not have the specific training needed to address a particular concern. If this is the case I will discuss it with you and make sure that you receive a referral to another professional who is better qualified to serve you.

I, the patient, consent to the above terms and agree to initiate treatment with Stephanie King PsyD (PSY 28314).

_____ _____

(Print name) (Date of Birth)

_____ _____

(Patient/Parent or Guardian Signature) (Date)

_____

(Address)

_____

(Emergency Contact – phone# - relationship)