

Agreement for Psychological Intervention

I understand that psychotherapy is a joint effort, the results of which cannot be guaranteed. The benefits of therapy are well known and at the same time I understand that I may have difficult or painful experiences such as unhappiness, anxiety, fear, anger, frustration etc. which may be a natural part of the therapy process. Progress depends upon many factors, including motivation, effort, and other life circumstances such as my interactions with family, friends and associates. In connection with the treatment program or consultation in which I am participating with Julie Kriegler, Ph.D. and after discussing this matter with her, **I hereby agree to participate and consent to the following:**

Please circle yes or no

- 1. yes no I will read and ask questions about the Notice of Health Information Privacy Practices and the General Information handouts which I have received. These handouts explain the terms of this agreement in more detail.
- 2. yes no I acknowledge that I have been informed that under California Law and/or HIPAA:
 - (a) if a patient communicates to a therapist a serious threat to physically harm an identifiable person, the therapist must attempt to warn that person and must notify the police;
 - (b) if the therapist knows of or suspects child abuse or neglect, or abuse of a dependent adult or an elder, a report must be made to the designated agency or to the police;
 - (c) if a patient seems dangerous to self or others, or is unable to care for him/herself, then hospitalization may be required and family members or supportive persons or authorities may be contacted.
- 3. yes no I understand that confidentiality will be maintained except when:
 - (a) we agree that certain information should be shared with a third party and I have signed an Authorization
 - (b) I have given written permission to exchange information from Psychotherapy Notes with another treatment provider for diagnostic purposes, continuity of care or treatment planning;
 - (c) consultation with another therapist would improve my treatment; or in therapist's absence;
 - (d) a court order, litigation or other official proceeding requires that information and records regarding my treatment, me or my family - otherwise confidential - must be provided without consent.
 - (e) disclosure is required by a government agency; a lawsuit or complaint against therapist; or a workers compensation claim.

I understand that:

- 4. yes no This consent covers me and any of my minor children involved in treatment.
- 5. yes no By my signature below, HIPAA allows the disclosure of protected health information from my clinical record for treatment, payment & health care operation purposes.
- 6. yes no I may withdraw from treatment at any time.
- 7. yes no My consent is voluntary, and (except for urgent consultations and the limitations on confidentiality listed in items 3 and 4 above) I may withdraw my consent to future disclosure at any time by providing a written request to Dr. Kriegler. Otherwise consent is in effect until one year from the date of our last session. Also, I may request revisions or deletions other than what is required by law.
- 8. yes no I understand that I may request a copy of this form.

PRINT NAME	SIGNATURE	DATE
PRINT NAME	SIGNATURE	DATE
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