DEBORAH C. WEISBERG
LMFT, LPCC

Informed Consent to Psychotherapy and Office Policies

As your therapist, I look forward to working with you and want to give you some important information about the services you will receive. This consent form will provide a clear framework for our work together and will facilitate our working relationship. Please feel free to discuss any questions you have with me.

1) CONFIDENTIALITY

As your therapist, I am legally prohibited from revealing to another person that you are in treatment with me, nor can I reveal what you have said to me in any way that identifies you without your written permission. However, in the following instances, your right to confidentiality must be set aside as required by law or professional guidelines:

A. Instances of actual or suspected physical or sexual abuse, emotional cruelty, or neglect of a child or an elder or dependent adult must be reported to the appropriate protective services.

B. If I have a reason to believe that a client poses an unavoidable and imminent danger of violence to another person (or to another's property), I must warn whomever may be in danger, and I must notify the appropriate authorities.

C. If a court has ordered your treatment with me, or if I am served with a subpoena. For example, in the context of a legal proceeding in which you raise your own psychological state as an issue, I am required to release information to the court, or may have to appear in court.

D. Finally, if you, as a client, reveal a serious intent to harm yourself, I am ethically bound to do what I can to help you keep safe, which may involve notifying others who may be of help.

In all of the above cases, it is incumbent upon me to release only that information necessary to appropriately carry out my responsibilities – your confidentiality still remains an ethical priority.

2) SESSIONS

Your weekly appointment time is reserved for you. Therapy sessions are 50 minutes long. Appointment cancellations must be made 48 hours in advance, otherwise, you are responsible for the fee for such sessions.

When therapy is being conducted with a couple on an ongoing basis, it can be counterproductive to the therapy process for the therapist to have information or private communications from one member of that couple, which are not known

to the other member. Therefore, it is therapist's policy that if a telephone call or other communication is received outside of the joint therapy session from one of the members of the couple, that communication will need to be shared with the rest of the couple at the next session, so that it may be discussed and utilized to assist the couple as a whole. With couples, both partners must be present for the session to occur; a no-show or late cancellation by one member will be billed in full, but the single member will not be seen alone as this can be counterproductive to trust and continuity.

3) PAYMENT FOR SERVICES

You are expected to pay for services at the time of our session, unless we have agreed on other arrangements. You may pay using cash, check or credit card. If you request it, I will give you a monthly statement, called a superbill, which you can use to bill your insurance for reimbursement. We will agree upon a fee at the outset of treatment. Any fee change is negotiated in good faith; it is your responsibility to notify me if your financial situation changes. Fees may change over the course of treatment, but with consideration to your financial ability to continue in treatment. Typically, fees will be raised once yearly. Fees for writing a psychological report or court appearances will be negotiated separately. In general, it is important to discuss with me any issues that arise connected to our financial arrangements, as they may impact our work together and/or be opportunities for therapeutic discussion.

Past due payments: If there is a balance of two sessions, another appointment cannot be scheduled until the balance has been paid. Payment for services which is past due over 120 days may be subject to collection through the use of a collection agency.

4) ACCESSIBILITY

Therapist will return calls within 24 hours or the next business day. Should you need to speak to me between sessions, I do not charge fees for telephone consultations that are less than 10 minutes. Consultations of longer than 10 minutes will be pro-rated to the nearest quarter-hour, based on your hourly fee.

I understand that Deborah C. Weisberg, LMFT, LPCC does not work on an emergency basis and does not carry a pager. If an emergency situation arises, I know that I should call 911 or go to the nearest hospital emergency room. Phone calls between sessions are typically limited to scheduling and other logistical matters, which must be arranged before the next session. If you encounter a serious psychological crisis between sessions and do not have a session scheduled in the next 12 hours, you will be encouraged to schedule one. The reason for this is that scheduled, in-person sessions, where the therapist has the time set aside for you, are the most effective way to obtain assistance. If there is a life-threatening psychological emergency and Deborah C. Weisberg, LMFT, LPCC does not have an appointment available in the next 12 hours, a brief telephone consultation may be provided to assist you until the next available appointment. Such crisis

consultations are charged at the standard fee, pro-rated to the nearest quarter-hour. Please note that most insurance carriers will not reimburse for telephone consultations.

I understand that Deborah C. Weisberg, LMFT, LPCC may not check email on a daily basis, and that email is not a confidential way to communicate. I understand that Deborah C. Weisberg, LMFT, LPCC is not responsible for any information transmitted via email or via Zoom or Facetime, if tele-mental health services are provided.

5) MINORS AND CONFIDENTIALITY

Communications between therapist and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in the treatment. Consequently, I may discuss the treatment progress of a minor patient with the parent or caretaker if deemed necessary. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic.

6) PATIENT RIGHTS

In addition to confidentiality, as spelled out above, you have the right to end your therapy at any time, for whatever reason, without any moral, legal or financial obligation, except for fees already incurred. You have the right to question any aspect of your treatment, and to expect that I will work with you to meet your needs for adjunctive or alternative treatment. You also have the right to expect that I will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you, all of which would greatly compromise our work together.

Psychotherapy involves a partnership between therapist and client. As your therapist, I will contribute knowledge, skills, and a willingness to do my best. The determination of success, however, will ultimately depend upon your commitment to your own personal growth and care.

Please feel free to ask any questions or discuss any of this information with me. Your signature below indicates that you have read and understand this information and have received a copy of this consent form.

Print Name of Client: _____

Signature of Client or Responsible Party: _____

Date: _____

DEBORAH C. WEISBERG

LMFT, LPCC

Fee Agreement

I understand my fee has been set at _____ per 50-minute session.

I have read the cancellation policy and understand how fees are charged and what I can do to ensure weekly meetings with my therapist.

I understand fees for treatment are payable at time of service.

I accept all major credit cards, however $5 will be added to your fee for processing. Fees can also be paid using cash and personal checks without the $5 processing fee.

By initialing here, _____, I am authorizing Deborah Weisberg, LMFT, LPCC to automatically charge my credit card on file for the fees associated with my treatment. This means, I am authorizing Deborah Weisberg to charge my treatment fee to my credit card when I have received services or when I have "late cancelled" an appointment.

Insurance: Should I wish to use my insurance, I understand I must request from Deborah Weisberg, LMFT, LPCC a document which contains dates of service, location of service, amount paid for service and a diagnosis code. I understand that only sessions I have paid for and attended will be included on the insurance document provided by my therapist. Please be aware that a mental health claim carries a certain amount of risk to your confidentiality, privacy, or the future eligibility to obtain health or life insurance. Insurance company computers will soon be linked to the congress-approved National Medical Data Bank which further increases vulnerability to unauthorized access.

If I have insufficient funds to cover my personal check at the time of its deposit, I will be required to pay the full amount of the check plus any bank fees incurred by Deborah Weisberg, LMFT, LPCC (normally between $10.00 – $35.00 per check.)

I understand my fee may be reviewed periodically, especially if my financial situation should change during the course of treatment. Any changes to my fee will take into account what I can afford. Should I become unable to pay the agreed upon fee for service, Deborah Weisberg, LMFT, LPCC will provide me with appropriate psychotherapy referrals to ensure continuity of treatment.

Balance on Account: If I leave treatment with an outstanding balance, I will need to make and maintain reasonable payments, discussed and agreed upon with my therapist, in order to bring the balance owed to zero.

By signing below, I am agreeing to the above terms.

Client Name: _____

Client's Signature: _____ Date: _____

DEBORAH C. WEISBERG

LMFT, LPCC

Notice of Privacy Practices (HIPAA)

The Health Insurance Portability and Accountability Act ("HIPAA") requires that I maintain the privacy of your medical information and provide you this notice in writing of my privacy practices.

I value the confidentiality of your personal health information ("PHI"). Your health information includes records that I create and obtain when I provide care to you, including records of your symptoms, diagnosis, treatments, test results, and referral for further care, in addition to bills and payment information, and insurance claims that I maintain related to your care. This notice describes how physical and mental health information about you may be used and disclosed, your rights regarding this information, and how you may access this information. Please review it carefully.

Except for the following purposes, I will use and disclose your health information only with your written permission:

(1) I may use and disclose your physical and mental health information for your treatment and to provide you with treatment-related health care services. I will disclose your physical and mental health information when required to do so by international, federal, state or local law.

(2) It is my policy that all routine or recurring uses and disclosures of your personal health information (PHI) must be limited to the minimum amount of information needed to accomplish the purpose of the use or disclosure. You may revoke the written permission at any time by writing to my office.

It is my policy to require an authorization for any use or disclosure of psychotherapy notes, as defined in the HIPAA regulations, except for treatment, payment or health care operations as follows: Use by me for treatment; use or disclosure in defense of a legal action brought by the individual whose records are in issue; use or disclosures as required by law, or as authorized by law to enable health oversight agencies to oversee the originator of the psychotherapy notes.

You have the right to inspect and/or receive a copy of your mental health information and billing records, except in limited circumstances, and a right to receive to all disclosures of you PHI. All requests, questions or complaints shall be made to me directly at the above address. If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services: Department of Health and Human Services, Office of Civil Rights, South United Nations Plaza, Room 322, San Francisco, CA 94102. Phone: (415) 437-8329; fax: (TDD) 415-437-8311.

I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices of Deborah Weisberg, LMFT, LPCC effective from the date written below:

Signature of patient: _____ Date: _____