INFORMED CONSENT FOR TREATMENT
JANICE MAURER, MA, LMFT, #99155

Welcome to my counseling practice. I am a licensed Marriage and Family Therapist, governed by specific laws and regulations and by a code of ethics for my profession in the State of California.

YOUR RIGHTS AS A CLIENT

You have the right to ask questions about any procedures or approaches utilized in therapy.

You have the right to decide at any time not to receive therapy from myself. If you wish, I will provide you with the names of other qualified professionals whose services you might prefer.

You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued.

CONFIDENTIALITY

Within certain limits, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your permission. At times, therapy will involve the participation of more than one family member and/or significant person(s). While I will attempt to follow your wishes, I do not guarantee confidentiality among participants in the family or couples therapy.

There are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. These situations include:

A. If you threaten bodily harm or death to another person, I, Janice Maurer, LMFT am required by law to inform the intended victim and appropriate law enforcement agencies.
B. If you threaten bodily harm or death to yourself, I, Janice Maurer, LMFT will inform the appropriate law enforcement agencies and other (such as spouse, friend, or an inpatient psychiatric institution) who could aid in prohibiting you from carrying out your threats.
C. If you reveal information related to the abuse or neglect of a child, dependent adult, or elderly person, I, Janice Maurer, LMFT am required by law to report this to the appropriate authorities.

"No Secrets" Policy for Family Therapy and Couple Therapy

This written policy is intended to inform you, the participants in family therapy or couple therapy, that when I agree to work with a couple or a family, I consider that couple or family (the treatment unit) to be the client. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-client privilege on behalf of the client (the treatment unit).

During the course of my work with a couple or family, I may see one part of the treatment unit (e.g. one spouse in the couple) for one ore more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third

party unless I am required by law to do so or unless I have your written authorization. In fact, since these sessions can and should be considered a part of the family or couple therapy, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This "no secrets" policy is intended to allow me to continue to treat the client (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interest of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of couple or family being seen, acknowledge by our individual signed initials below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with Janice Maurer, LMFT and that we enter couple/family therapy in agreement with this policy.

Each family member must initial:

Initials _____ Initials_____ Initials_____ Initials_____

MINORS

If you are the guardian of a minor or are a minor, please read the following: By signing below, I give my consent for Janice Maurer, LMFT to conduct therapy sessions with the minor listed below. I have also been informed of the limitations of confidentiality in terms of the topics discussed in treatment regarding substance use and sexual activities. I accept Janice Maurer's judgment in regards to releasing information related to the treatment of this minor. In addition, I understand that at anytime if Janice Maurer believes this minor is in danger of hurting him or herself, I will be notified immediately.

CONTACT INFORMATION

Janice Maurer, LMFT can be reached at (925) 872-8812, Monday through Friday from 9:00 AM to 5:00 PM. If you have a counseling emergency after hours, please call the 24-Hour Emergency Crisis Line at 1-800-479-3339 or 911.

Email communication is for **non-emergencies only**. It may be used for appointment changes, referrals and non-clinical questions. I check my emails daily, Monday through Friday, but if you are cancelling an appointment with less than 24 hours notice, please call my cell phone number. **Email**: janicemaurermft@gmail.com

APPOINTMENT CANCELLATION OR "NO SHOWS"

If you wish to cancel or reschedule an appointment, contact my office at least 24 hours in advance. I reserve the right to charge for "no shows" and sessions not cancelled within 24 hours of your appointment.

CLEAN AND SOBER POLICY

I ask that you come to your sessions at least 24 hours clean and sober. This is to insure the best work can be accomplished with a clear mind. If you come to a session under the influence, I reserve the right to end the session and charge for that appointment. I may also call your emergency contact to insure you have a safe exit from my office.

FEE ACKNOWLEDGMENT AND AGREEMENT

The undersigned, by providing his/her signature in the space below agrees to accept the therapy services provided by Janice Maurer, LMFT in accordance with and pursuant to the terms and conditions set forth herein.

The fee for individual/couple counseling sessions will be billed at $120 per 50 minute session. Counseling sessions for couples/family can be scheduled for 75 minutes and will be billed at $165.00 per session, based on availability. Payments are required at the time of your appointment. If at any point in the course of treatment you are unable to pay for your fee, please communicate this to your therapist and your feel may possible be negotiated.

All outstanding balances remaining unpaid more than 30 days will be charged directly to your credit card. If the credit card does not authorize payment, you are subject to interest accrued at a rate equal to 10% per annum of such outstanding balance.

The undersigned hereby authorizes Janice Maurer, LMFT to charge my credit care (provided below) for the amount of any balance remaining at the end of each therapy session or after a balance has been unpaid for 30 days.

I am authorizing Janice Maurer, LMFT to charge my card when I do not show up for my scheduled appointment or if I cancel in less than 24-hour notice. The charge for a "no show or late cancellation" is the same as a full session fee, agreed upon this document.

Preferred method of payment (please circle one): Credit Card Cash Check

____ Client Initials _____ Client Initials

CREDIT CARD INFORMATION:

The undersigned hereby authorizes Janice Maurer, LMFT to charge my credit card (provided below) for the amount of any balance remaining at the end of each billing period. If payment by check is the preferred method agreed upon, the following card will only be charged if there is an outstanding balance more than 30 days after issuance of an invoice.

A current credit card number must be on file at all times, regardless of your preferred method of payment. Your card will not be charged if you choose to pay by check or cash at the time your payment is due. If credit is your preferred method of payment, your card will be charged at the time of each session.

Should you elect to pay for your therapy sessions with a credit card, please provide your credit card information below. Please inquire about anything that is unclear prior to signing the credit card authorization section of this form. By providing your signature, you agree to the following:

- Session fees are due and payable no later than the end of the session.
- Charges for telephone sessions are due and payable no later than the end of the session.
- Missed sessions or sessions not cancelled at least 24 hours in advance will be charged to your credit card at the regular therapy rate.
- If a charge is not honored, client agrees to be responsible for all associated fees. If client later reverses an authorized and legitimate charge, client is responsible for fees associated with the chargeback.

Charges on your credit card statement will appear as: Janice Maurer, LMFT

Circle credit card used: VISA MasterCard American Express Discover Card

Name as it appears on credit card (please print)_____

Credit Card Number _____ Exp. Date _____

Security Code _____ Billing Zip Code _____

With my signature, I certify that I am an authorized signer on the above credit card account. I authorize Janice Maurer, LMFT to make charges to my credit card for therapeutic services rendered. I agree to the credit card terms set forth above.

SIGNATURES – PLEASE SIGN BELOW

The undersigned, by providing his/her signature in the space below agrees to accept the therapy services provided by Janice Maurer, LMFT in accordance with and pursuant to the terms and conditions set forth herein.

1) Name (Please print) _____

   Signature _____ Date_____

2) Name (Please print)_____

   Signature_____ Date_____

____ Client Initials _____ Client Initials

_____ _____

Janice Maurer, Licensed Marriage & Family Therapist, #99155 Dated

For the adult(s) who have the legal authority under the law to consent for the minor-aged person to receive counseling services from Janice Maurer, LMFT:

As the parent(s) or guardian(s) of _____, I the undersigned give my consent to Janice Maurer, LMFT, #99155 to provide counseling treatment to _____. By signing below, I acknowledge the necessity of confidentiality between the minor child and his/her therapist which best supports the creation of an effective counseling relationship. I, hereby acknowledge that I have been informed of the limitations of confidentiality by Janice Maurer, LMFT as outlined in the laws, regulations, and code of ethics according to the State of California, Board of Behavioral Sciences.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

____ Client Initials _____ Client Initials