

Gelareh Solomon, Ph.D.

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CONSENT TO TREATMENT

Name Date of Birth

Home address City

State Zip code Social Security number

Cell phone number Other phone number

Welcome. Psychotherapy is unique in that it is highly personal work and, at the same time, involves a contractual agreement. It is important that you have a clear understanding of how the therapeutic relationship can work and what each of us can expect.

Limits of Confidentiality. Psychotherapy is a personal and confidential process. This means that I will not share what we discuss with others. This is a legal and ethical obligation that I take very seriously. As such, it is important for you to be aware of the few exceptions to my ability to keep your information private. Confidentiality may be suspended and the proper authorities notified under the following circumstances:

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are where there is a reasonable suspicion of child, dependent or elder abuse or neglect or where a client presents a danger to self, to others, to property, or is gravely disabled.

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by me. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless I am authorized to do so by **all** adult family members who were part of the treatment. ***If this treatment is Court-Ordered and feedback will be required to Court, by signing this Consent you will waive your rights to confidential treatment so that information obtained in this treatment may be released to the Court.***

Health Insurance & Confidentiality of Records: If you intend to use health insurance to pay for any part of your treatment, disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so

instruct, only the minimum necessary information will be communicated to the carrier.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf, will call on me to testify in Court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Consultation: I consult regularly with other professionals regarding my clients, however the client's name or other identifying information is never mentioned. Your identity remains completely anonymous, and confidentiality is fully maintained.

* Considering all of the above exclusions, if it is still appropriate, upon your request, I will release information to any agency/person you specify unless I conclude that releasing such information might be harmful in any way.

Nature of Treatment. Psychotherapy has both benefits and risks. The benefits are specific to each individual and may include the resolution of specific concerns that led you to seek therapy, lessening of distressful feelings, symptom reduction, and improved relationships with others. Working toward these benefits requires active involvement on your part. Remembering or talking about unpleasant events, feelings, or thoughts may result in experiencing discomfort and strong feelings. For these reasons, it is possible to experience an increase in symptoms during the course of treatment.

Coordination of Care. It is often helpful to address mental health concerns through multiple methods of treatment (i.e., therapy and medications). It is your duty to notify me, both at the outset of treatment and ongoing, if you are receiving treatment of any kind which relates to our work together. If I determine that communication between me and your other providers would be beneficial, I may ask you to sign a "Release of Information" form granting me permission to release or exchange information and records pertaining to you and your treatment.

Payment and Fees.

Treatment fees, once agreed upon, should be paid at the onset of each session or unless other, specific arrangements have been made. You may pay by cash or check (payable to Dr. Gelareh Solomon). Any fee change is negotiated in good faith; it is your responsibility to notify me if your financial situation changes. Other services such as report writing, attendance at meetings, phone conversations longer than ten minutes, preparation of records or treatment summaries, or other requested services will be billed on a prorated basis. If you become involved in legal proceedings that require my participation, you will be expected to pay two times my full fee for my professional time doing any preparation, attendance or testimony. In the case of couples or family psychotherapy, you are responsible jointly and severally for the fee for the services that are received from me, even though you may have a different agreement between you. My fees may change over the course of treatment but with consideration to your financial ability to stay in treatment. Typically, fees will be re-evaluated twice yearly.

I will provide you with whatever assistance I can to facilitate your receipt of insurance benefits to which you are entitled, including filling out forms as appropriate. However, you, and not your insurance company, are responsible for full payment of the fee that we have agreed to. Therefore, it is very important for you to find out exactly what mental health services your policy covers. In some cases, advance authorization may be necessary, a deductible may need to be met, and the amount of coverage may be limited. You should be aware that most insurance agreements require you to authorize me to provide clinical information, a diagnosis, a treatment plan or summary, or even a copy of the entire record. Once they have this information, I have no control over what the insurance company does with the information. As was indicated in the section, Health Insurance

& Confidentiality of Records, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are the focus of psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.

Since the scheduling of an appointment involves the reservation of time specifically for you, you will be expected to pay for the appointment unless you provide at least 24 hours notice for rescheduling or cancellation. There is a \$25.00 charge on all returned checks. If your account becomes delinquent and suitable arrangements for payment have not been agreed to, I have the option of using legal means to secure payment, including small claims court. In most cases, the only information released would be that required to obtain payment, including the patient's name, nature of services provided, and amount due.

Cancellation Policy. Regular attendance is crucial to the effectiveness of therapy. Together we will decide on regular session time(s), which I will reserve for you each week. Sessions are 45 minutes in length. *If you need to cancel a session, you must do so at least 24 hours in advance, or you will be financially responsible for the missed session.* Provided I have another appointment time available, you may reschedule for another time during the same week without charge.

Termination. You have the right to terminate therapy at any time; however, planned termination can be a valuable part of the therapeutic process. For your benefit, I request that we have at least one in-person termination session to process the ending stages of treatment, assess progress, and address issues related to follow-up care or referrals.

If You Need To Contact Me. If you need to contact me between sessions, you may leave a message for me at (424) 262-5026. Please be aware that I cannot always be reached by phone immediately, however, I will make every effort to respond to your call in a timely manner. If an emergency arises and you need immediate assistance, call 911, or go to the nearest Emergency room and inform them that you are in crisis.

If I am going to be unavailable for an extended time, I will provide you with the name of a trusted colleague whom you can contact as necessary.

Acknowledgement and Consent. Your participation in therapy is voluntary. By signing this form, you are acknowledging that you have read and consent to the information and policies as outlined above.

Patient signature

Date

Parent/Guardian signature (if necessary)

Date

Therapist signature

Date

If Minor Patient:

I certify that I have the sole authority to provide consent for this minor to receive treatment, and/or certify that the consent of no other parent or party is required for this minor to receive

treatment. If any such other consent is required, I have provided or will immediately provide Dr. Gelareh Solomon with evidence that that treatment consent has been granted. I agree to provide a copy of any Court agreement that identifies who is authorized to provide such consent for this minor.

Signature of Parent/Legal guardian (if minor patient)

Date

Signature of Parent/Legal guardian (if minor patient)

Date