LARRY GOODMAN, LMFT

Licensed Marriage and Family Therapist #38345

78022 Red Hawk Lane

La Quinta, CA 92253

**AGREEMENT FOR PSYCHOTHERAPY AND**

**INFORMED CONSENT**

**Introduction**

This Agreement is intended to provide \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (herein “You”, “Patient” or “Client”) with important information regarding the psychotherapy practices, polices and procedures of Larry Goodman. LMFT, (herein “Therapist” “me,” or “I”) and to clarify the terms of the professional therapeutic relationship between You and me. Please discuss any questions or concerns regarding the contents of this Agreement with me prior to signing it.

**Therapist Qualifications**

I am a licensed Marriage and Family Therapists (MFT) working primarily with children, teens, adults, couples, and families dealing with various issues and symptoms including but not limited to family issues, grief, divorce, parenting, AD/HD, anxiety and depression. My theoretical orientation can be described as Cognitive Behavioral Therapy (CBT) and eclectic.

**Risks and Benefits of Therapy**

Psychotherapy is a process in which the therapist and the Client, and sometimes other family members, discuss issues, events, experiences and memories for the purpose of creating positive change so the Client can experience his/her life more fully. Psychotherapy is a joint effort between the Client and the therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Participating in therapy may result in a number of benefits to the Client, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. Such benefits may also require substantial effort on the part of the Client, as well as his/her caregivers and/or family members, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. ***There is no guarantee that therapy will yield any or all of the benefits listed above.***

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. This discomfort may also extend to other family members, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, anger, fear, etc. The issues presented by You may result in unintended outcomes, including changes in personal relationships. During the therapeutic process, many Clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift, at times, but may also be slow and frustrating. Please address any concerns You have regarding progress in therapy with me.

**Discussion of Treatment Plan**

I will discuss my working understanding of the problem, treatment plan, therapeutic objectives and possible outcomes of treatment with You. If You have any questions about the procedures used in the course of the therapy, possible risks, my expertise in employing them, or about the treatment plan, please ask and I will answer them. You also have the right to ask about other treatments for the Your condition and their risks and benefits. If You could benefit from any treatment that I do not provide, I have an ethical obligation to assist You in obtaining those treatments.

**Records and Record Keeping**

I am required to secure client records containing individually identifiable health information so that they are not readily available to those who do not need them.

Both federal and California law allow patients to review, receive copies of, or ask for amendments of, their health records. Under HIPAA law, patients cannot access psychotherapy notes. Under California law, the health care provider may decline to permit inspection or provide copies of psychotherapy notes to a Client only if the health care provider determines there is a "substantial risk of significant adverse or detrimental consequences to the Client in seeing or receiving" such psychotherapy notes (H&SC §123115(b)).

Client records consist of the dates of treatment sessions; fees and payments; clinical information such as diagnosis, treatment plan, records of any testing, and records gathered from other providers. Psychotherapy Notes are information in the Client’s record that the mental health provider uses to describe and justify the treatment provided.

I will not alter my normal record keeping process at the request of any Client or Parent or Guardian. Should You request a copy of my records, such request must be made in writing. I reserve the right, under California law, to provide You with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider in accordance with California law.

I will maintain Your records for ten years following termination of therapy, or when You are 21 years of age, whichever is longer. However, after ten years, Your records will be destroyed in a manner that preserves Your confidentiality.

**Confidentiality**

I know how important the privacy and confidentiality of our work together is for You, and I recognize that during the course of therapy, You may be revealing very personal and sometimes embarrassing details of Your life to me. Full, open, and frank communication is an important factor influencing the outcome of therapy. Before we commence treatment, I do want to inform You that under California law and the ethical standards of our profession, You are entitled to confidentiality in our work together. However, the duty of confidentiality is not absolute. There are many exceptions to confidentiality, some of which are mandatory and some of which are permissive. While most or many of these exceptions may not apply to You individually, I cannot predict with any accuracy what will develop as we proceed with Your treatment. Therefore, in the spirit of full disclosure, I want to inform You of the following exceptions to Your privacy and confidentiality – times when I may be required or permitted to make disclosures, at least to some degree, about You or Your treatment without Your written authorization:

1. If disclosure is compelled by the reporting laws for child abuse, elder abuse and dependent adult abuse – e.g., when I reasonably suspect that **child, elder or dependent adult abuse or neglect has occurred**.
2. If disclosure is required or permitted because You are in such mental or emotional condition to be **dangerous to Yourself or to others**.
3. If disclosure is required or permitted **when You communicate to me, either directly of indirectly, an imminent and serious threat of physical violence against a reasonably identifiable other person.**
4. If You sue me for alleged negligence or malpractice, I will share Your treatment records and other information with my attorney and my insurer, or if I have to sue You for fees owed by You, the fact of my professional relationship may be disclosed in the lawsuit.
5. If I decide to consult with another health care provider for purposes of Your diagnosis or treatment, Your treatment records and communications with me may be revealed.
6. In the event of your death, disclosures may be made to a coroner to determine, among other things, the cause of Your death.
7. If You file a complaint against me with the state licensing board, I may forward Your records and other information to my attorney and to the licensing board or if You file a complaint against me with the Ethics Committee of my professional association, I may reveal Your records and other information in the course of that proceeding.
8. If You file a claim for reimbursement with an insurer, I may share information with the insurer about Your diagnosis, progress, prognosis, and the treatment plan.
9. If I am ordered by a court to disclose records or information pertaining to You or Your treatment.
10. If there is a search warrant lawfully issued to a governmental law enforcement agency authorizing the seizure of Your records.
11. If disclosure is compelled by a part to a proceeding before a court or administrative agency pursuant to a subpoena for my appearance and testimony or a subpoena for Your records pertaining to Your treatment.
12. **If I require the services of a collection agency because of any unpaid billing for my services, I may share information with the agency regarding the amount unpaid for my services along with Your name and address**.
13. If disclosure is otherwise required or permitted by law.
14. It should be understood that communicating confidential information via email, text messages or video-conferencing may not be secure in that the confidentiality of those communications may be breached. Threats to Your confidentiality include but are not limited to: 1) the transmission may be intercepted; 2) the transmission may be sent to the wrong recipient; and 3) the email or text message may be accessed by an unauthorized person. You have the right to decline these communication services and I will respect your right and wishes.

**You understand and agree to all of the reasons above. \_\_\_**

Please feel free to ask me about any of these exceptions to confidentiality. We can discuss these public policies in more detail if You have any questions.

**Professional Consultation**

Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding You as a Client.

**Telehealth/Telemedicine/Online Therapy**

I offer psychotherapy via telephone or video to clients who are traveling or who cannot travel to my office. While there may be minimal risks, the benefits of continuous treatment over breaks in ongoing treatment can outweigh potential risks. The benefits of telemedicine have been recognized in California state law. If You have any questions, please discuss them with me. Note the issue of potential breaches of confidentiality in the section above.

**Duty to Warn**

In the event that I reasonably believe that the You are a danger, physically or emotionally, to Yourself or another person, You specifically consent for me to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

NAME TELEPHONE NUMBER

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**Communication**

You consent for me to communicate with You by mail and by phone at the following addresses and phone numbers, and will IMMEDIATELY advise me in the event of any change:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychotherapist-Client Privilege**

The information disclosed by You, as well as any records created, is subject to the Psychotherapist-Client privilege. The Psychotherapist-Client privilege results from the special relationship between You and me in the eyes of the law. It is akin to the Attorney-Client privilege or the Doctor-Patient privilege. Typically, You are the holder of the Psychotherapist-Patient privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the Psychotherapist-Client privilege on Your behalf until instructed, in writing, to do otherwise by You or Your representative. You should be aware that You might be waiving the Psychotherapist-Client privilege if You make Your mental or emotional state an issue in a legal proceeding. You should address any concerns You might have regarding the Psychotherapist-Client privilege with Your attorney.

**Fee and Fee Arrangements \_\_\_**

The agreed-upon fee between You and me for services rendered **is $\_\_\_\_** **per 60 minute session.**  **You agree to pay for each session prior to the session if using an online payment system (e.g Zelle) or with a credit card at the time of the session**.

Sessions longer than 60 minutes will be pro-rated and rounded for the additional time. I reserve the right to periodically adjust this fee. You will be notified of any fee adjustment in advance.

From time-to-time, I may engage in telephone contact with You for purposes other than scheduling sessions. You are responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, I may engage in telephone contact with third parties at Your request and with Your advance written authorization. You are responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. You are expected to pay for services at the time services are rendered. I accept cash, checks and credit cards.

At times, I may be asked to support You in meetings outside of my office (e.g., schools, legal or other professionals). You agree to pay for my time outside the office including travel time.

**Client Litigation**

I will not voluntarily participate in any litigation, or custody dispute in which You and another individual, or entity, are parties. I have a policy of not communicating with a Patient’s attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Your legal matter. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving You, You agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate. **\_\_\_**

**Insurance**

I, Larry Goodman, LMFT, am a contracted provider with TRICARE and may submit claims on behalf of my patients who are members of TRICARE for a contracted fee. Copays shall be paid at the beginning of each session. I am not contracted with any other insurance company.

If You choose to use insurance and submit my billing statements to Your insurance company, You remain solely responsible for the session fee regardless of the expected or unexpected insurance reimbursement. Fees are payable at the beginning of each session. It is Your responsibility to deal with deductibles and changes in reimbursement rates by the insurance company. You may submit billings from me to Your insurance company for an “out of network provider.”

I will provide a billing statement that You can submit to Your insurance company to seek reimbursement of fees already paid. That billing statement will contain a mental health disorder diagnosis. There is no guarantee of confidentiality for that information once it leaves my office. You understand and agree to the possible implications of providing this information to Your insurance company. \_\_\_

**Cancellation Policy**

**You are responsible for payment for any missed session(s) for which You failed to provide at least *24* *hours* notice of cancellation at the full agreed-upon fee.** Cancellation notice should be left on my office voice mail at 760-766-1622. Insurance companies may not reimburse for missed sessions. **In order to protect against late cancellation and Your failure to pay for a missed session, You agree that I will charge Your credit card for the missed session at my current hourly rate.**  \_\_\_

Please provide your credit card information as follows:

Name on Credit Card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Number \_\_\_\_-\_\_\_\_-\_\_\_\_-\_\_\_\_ Expiration Date \_\_ / \_\_ / \_\_ Security Code \_\_\_\_

**Mediation and Arbitration**

All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement between myself and You. The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in the local county in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. In the event that Your account is overdue (unpaid) and there is no agreement on a payment plan, I may use legal means (collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceeding shall be entitled to recover a reasonable sum for attorney’s fees. In the case of arbitration, the arbitrator will determine that sum.

**Therapist Availability**

My office is equipped with a confidential voice mail system (760-766-1622) that allows You to leave a message at any time. I will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. *I am unable to provide 24-hour crisis service*. **In the event that the You are feeling unsafe or requires immediate medical or psychiatric assistance, You should call 911, or go to the nearest emergency room**.

**Therapist’s Incapacity or Death**

You acknowledge that, in the event that I become incapacitated or die, it will become necessary for another therapist to take possession of Your file and records. By signing this form, You give consent to allowing another licensed mental health professional selected by me to take possession of the Your file and records and provide copies upon request, or to deliver them to a therapist of the Your choice.

**Dual Relationships**

Your relationship with me is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that I do not have any other type of relationship with You. Therapy never involves a sexual or other dual relationship that can be exploitive in nature. Personal or business relationships undermine the effectiveness of the therapeutic relationship and may impair my objectivity, clinical judgment, and effectiveness. Gifts, bartering and trading services are also not appropriate.

**Termination of Therapy**

I reserve the right to terminate therapy at my discretion. Reasons for termination include, but are not limited to, untimely payment of fees, conflicts of interest, Your needs are outside of my scope of competence or practice, or You are not making adequate progress in therapy. You have the right to terminate therapy at Your discretion. Upon either party’s decision to terminate therapy, I generally recommend that You participate in one or more termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. I will also attempt to ensure a smooth transition to other therapists by offering referrals to You.

“NOTICE TO CLIENTS: The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of professional clinical counselors. You may contact the board online at [www.bbs.ca.gov](http://www.bbs.ca.gov/), or by calling (916) 574-7830.”

**Acknowledgement**

By signing below, You acknowledge that You have reviewed, initialed and fully understand the terms and conditions of this Agreement. You have discussed such terms and conditions with me, and have had any questions with regard to its terms and conditions answered to Your satisfaction. You agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with me. Moreover, You agree to hold me free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

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Client Name (please print)

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Signature of Client (or authorized representative) Date

You understand that You are financially responsible for charges for psychotherapy services provided.

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Name of Responsible Party (Please print)

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Signature of Responsible Party Date