LARRY GOODMAN, LMFT

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**Informed Consent and Agreement**

**for**

**Psychotherapy Treatment**

Welcome to my practice. This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents.

**Information About Your Therapist**

At an appropriate time, I may discuss my professional background with you and provide you with information regarding my experience, education, special interests, and professional orientation. You are free to ask questions at any time about any of these.

I am licensed as a Marriage and Family Therapist (MFT) in California.

**About the Therapy Process**

It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Over the course of therapy, I will attempt to evaluate whether the therapy provided is beneficial to you. Your feedback and input is an important part of this process. It is my goal to assist you in effectively addressing your problems and concerns. However, due to the varying nature and severity of problems and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

Typically, therapy sessions are approximately **50 minutes** each and are scheduled once per week, at the same day and time each week. Consistent attendance contributes greatly to a successful outcome.

**Fees and Insurance**

The fee for service is $180 for individual, couples, children, teen and family therapy for the 50-minute sessions. Longer sessions are prorated based on the $180 fee (e.g., a 75-minute session would be charged at $270, 1½ x $180). If I am required to travel on your behalf, you agree to pay for my time outside the office including travel time.

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 and any meetings outside of your session.

Fees are payable at the time services are rendered. I accept payment in the form of **Zelle or credit cards.** My goal is to maximize your session time. If you are paying for a session via a debit card or credit card, please let me know ahead of time.

You are ultimately responsible for payment for services received, even if you are relying on, or expecting, your insurance company or another third-party payor to cover the costs of treatment. I will notify you in the event of any changes to fees or when other charges are to be applied. If you are experiencing financial difficulty, please let me know so we can discuss your care options.

Please inform me if you wish to use health insurance to pay for your services. I am an in-network provider for the Tricare health plan but **“out of network” for all other plans.** If you wish, I will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible payments depends on the requirements of your specific insurance plan. Please be aware that insurance plans generally limit coverage to diagnosable mental conditions. You are responsible for verifying and understanding limits of your insurance coverage. Although I am happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee that your insurance will provide payment for the services provided to you.

## **Appointment Scheduling and Cancellation Policies**

Sessions are typically scheduled to occur once per week on the same day at the same time, if possible. I may suggest a different amount or frequency of therapy depending on the nature and severity of your concerns. Your consistent attendance can greatly contribute to a successful therapy outcome. **To cancel or reschedule an appointment, please notify me at least 24 hours in advance of your appointment**. If you do not provide me with at least **24** hours’ notice of a cancellation, I will charge you $170 for the missed session. If you are using insurance, please be aware that your insurance company will not pay for missed or cancelled sessions. Accordingly, you will be responsible for covering the cost of missed sessions and sessions cancelled within **24** hours of the scheduled session.

To facilitate payment for missed sessions, please provide your credit card information including:

Credit card # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration date \_\_/\_\_ Security code \_\_\_\_\_\_\_ and your Zip code \_\_\_\_\_\_\_\_\_\_.

*This information will be protected and kept safe.*

## **Your Right to Confidentiality**

As a psychotherapy patient, you have a right to confidentiality with respect to information related to our work together. Accordingly, information shared between us will generally remain confidential.

## **Exceptions to Confidentiality**

In certain, limited instances, the law requires me to disclose information pertaining to my work with you. For example, as a therapist, I am required to report suspected child, elder, and dependent adult abuse. Please note that the legal definition of “child abuse” generally includes instances of “sexting” in which a person *of any age* captures, records, sends, receives, or possesses an image or video depicting a minor engaged in sexual or otherwise obscene conduct.

Similarly, in the event that I believe you present a serious and imminent danger to yourself, another person, or the public, I may be required to disclose information to emergency medical services, law enforcement, and/or another third party that can help to reduce or prevent that danger.

## **Confidentiality and Treatment of Minors**

If a minor’s parent(s) or guardian(s) give consent for me to treat the minor, I typically provide the parent(s) or guardian(s) with general updates about the minor’s treatment. These updates may include the minor’s diagnosis, treatment plan, progress in therapy, session attendance, or similar information. However, I generally do not share specific details about the minor’s treatment or what the minor has shared with me during sessions unless: 1) the minor gives me permission to disclose such information and I believe the disclosure would be clinically appropriate; or 2) the minor is experiencing a crisis or other emergency circumstance that would authorize me to break confidentiality.

If the minor consents to their own treatment, the law generally prohibits me from communicating with their parent(s) or guardian(s) without written authorization from the minor unless the minor is experiencing a crisis or other emergency circumstance that would authorize me to break confidentiality.

Please feel free to reach out to me if you have questions about these policies or if you would like to discuss them further.

## **Confidentiality and Couples / Family Therapy**

If you are participating in couples or family therapy, please be aware that, in most circumstances, the law prohibits me from disclosing confidential information and records regarding the unit of treatment’s services unless *all* identified patients provide written authorization to release the information.

***No Secrets Policy***

I would also like for my couples and family therapy patients to be aware that I utilize a “no-secrets” policy. This means, when I determine it is clinically appropriate or necessary to do so, I am able to disclose information I obtain from one member of the couple, or a participating member of the family therapy unit, (i.e. the “treatment unit”) with the other member(s) of the treatment unit. This policy also applies to information a member of the treatment unit shares with me outside of couples / family sessions (e.g., via email, text, etc.) and information I obtain during individual session(s) with a member of the treatment unit (should we agree to hold individual sessions in furtherance of your couples / treatment goals). I find that this policy facilitates effective communication with and between my couples and family therapy patients. It also helps me to avoid potential problems which may arise when a therapist is perceived to be “keeping secrets” from other members of the treatment unit.

**Therapist Availability/Emergencies**

You are welcome to phone or text me between sessions. However, as a general rule, it is my belief that important issues are better addressed within regularly scheduled sessions.

You may leave a message for me at any time on my confidential voicemail at 760-766-1622. If you wish me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during the therapist’s normal workdays within 24 hours. If you have an urgent need to speak with me, please indicate that fact in your message and follow any instructions that are provided by my voicemail. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance or go to the nearest emergency room or call 988 for suicide support.

Please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call.

You should be aware that I am generally available to return phone calls within approximately 4 hours. I am not able to return phone calls after 9 pm. I may not be available to return phone calls on weekends.

If you have an urgent need to speak with me, please indicate that fact in your message.

You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis:

Suicide Crisis Hotline: (800-273-8255 or 988) Police (911)

Eisenhower Emergency Room (760-773-1221) CPS (800-442-4918)

## **My Communication with You**

From time to time, I may need to communicate with you outside of our sessions together to discuss scheduling, payment, or other issues related to your treatment. To respect your privacy, it is important for me to understand your communication preferences. Please indicate your openness to receive communication from me via the following methods

#### Phone

\_\_ Larry may call me on my home phone. My home phone number is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Larry may leave a message on my home phone.

\_\_ Larry may call me on my cell phone. My cell phone number is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Larry may leave a message on my cell phone.

\_\_ Larry may send a text message to my cell phone.

\_\_ Larry may communicate with me by e-mail. My e-mail address is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Larry may send a fax to me. My fax number is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Additional Information About Unencrypted Text Messaging*: I value your privacy and take appropriate steps to preserve the confidentiality of information shared between us. However, it is important to be aware that certain risks may still be present when communicating via unencrypted text, such as technological failures or unintended access by third parties.

* I understand the information above and authorize my therapist to communicate with me via unencrypted text using the cell phone number I provided.

#### Email

My Email Address is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I understand the information above and authorize my therapist to communicate with me via unencrypted email at the email address I provided.

#### Mail

My Home Address is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize my therapist to send necessary, treatment-related information to me at this address.

#### **Emergency Contact**

It is critical for me to know who I can contact in the event that you are experiencing a medical or psychiatric crisis or other emergency circumstance. Please identify these individuals in the space provided below:

Emergency Contact:

Name. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sensitive, clinical information may be discussed over the phone or in-person as deemed appropriate by me. For appropriate e-mail or text communication, I will respond to your e-mail or text within 24 hours. E-mail messages may contain viruses or other defects and it is your responsibility to ensure that it is virus-free. In addition, e-mail or text communication may become part of the clinical record. You may be charged for time I spend reading and responding e-mail or text messages.

**Termination of Therapy**

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

## **Informed Consent**

Your signature indicates that you have read this agreement for services carefully and understand and agree to its contents. Please ask me to address any questions or concerns that you have about this information before you sign.

Name(s) of Patient(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient (if Applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent and Minor)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_