

**Dr. Nadieh Kakar, LMFT**

**Informed Consent & Agreement for Psychotherapy Services**

**Introduction**

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 before signing it. You may have questions about me, my qualifications, therapy, or anything not addressed here. It is your right to have a complete explanation for any questions you may have, now or in the future. Please feel free to ask questions or share any concerns that may arise. Although I know this may be uncomfortable at times, your openness and honesty will allow me to better serve you. Information about Your Therapist. Whenever you wish, I will 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 the above, and anything else related to your therapy or other concerns. I am licensed in California under Nadieh Kakar, LMFT and my license number is 97448.

**Fees**

The fee for service is \$175.00 per 45–50-minute therapy session. I reserve the right to periodically adjust the fee. You will be notified of any fee adjustment in advance. Fees are payable at the time that services are rendered. Please ask me if you wish to discuss a written agreement that specifies an alternative payment procedure. If there is a need for telephone contact, with you or a third-party, other than for scheduling purposes, you understand that you are responsible for payment of the agreed-upon fee (on a pro rata basis) for any calls lasting longer than 10 minutes.

**Appointment Scheduling and Cancellation Policies**

Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. Scheduled appointment times are reserved especially for you. If an appointment is missed, or canceled with less than 24 hours' notice, you (not your insurance company) will be charged the full fee for that missed session. Exceptions may be made if you are sick or have an unavoidable emergency. If you no-show for two sessions in a row and do not respond to my attempts to reschedule, I will assume that you have dropped out of therapy and will make the space available to another individual.

**Client initial here: \_\_\_\_\_**

**Insurance** Please inform me if you wish to utilize health insurance to pay for services. I will discuss the procedures for billing your insurance. Although I am happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions, which then become part of your medical record, and generally have a set number of sessions they approve you for. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. You are responsible for obtaining prior authorization for treatment from your insurance carrier. If you are not covered by your insurance at the time of service, you are responsible for payment for the full fee for service, which is \$175.00 per session. Please discuss any questions or concerns that you may have about this with me. If for some reason you find that you are unable to continue paying for your therapy, please inform me. I will help you to consider any other options that may be available to you at that time. In addition, if going through insurance and you miss three (3) sessions, we will discuss possible referral and/or terminating therapy.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Though a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will try to assist you in finding another provider who will help you continue your psychotherapy.

### **Delinquent Accounts**

You understand that you are responsible for all charges incurred and that services must be paid in full at the time of each visit, unless other arrangements have been made in advance. Should your account become delinquent, you agree to pay interest at 1.5% per month, and if it becomes necessary for the account to be referred for collection action, you agree to pay the actual balance due plus any collection expenses of 30-50% of any balances owing, and any attorney's fees.

### **Risks and Benefits of Therapy**

Psychotherapy is a process in which we will discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so that you can experience your life more fully. It provides an opportunity to better and more deeply understand one self, as well as any problems or difficulties you may be experiencing. Psychotherapy is a joint effort between us. 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 you, 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, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on your part, 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.

**Client initial here: \_\_\_\_\_**

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, anxiety, etc. There may be times in which I will challenge your perceptions and assumptions, and offer different perspectives. The issues presented by you may result in unintended outcomes, including changes in personal relationships. Sometimes a decision that is positive for one family member is viewed quite differently by another. You should be aware that any decision on the status of your personal relationships is your sole responsibility. During the therapeutic process, many people 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. You should discuss with me any concerns you have regarding your progress in therapy. 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.

**Discussion of Treatment Plan.** It is my intention to provide services that will assist you in reaching your goals. Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives and my view of the possible outcomes of treatment. Sometimes more than one approach can be helpful in dealing with a certain situation. During the course of therapy, I will draw on various treatment approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches may include but are not limited to behavioral, cognitive, CBT, solution focused, psychodynamic, system/family, developmental, and/or psycho-educational techniques. I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for 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.

### **Confidentiality**

If you elect to communicate with me by email at some point in our work together, I am willing to respond briefly by return email, but please be aware that email and other electronic media are not completely confidential. I do not use an encrypting program on email at this time. The following are legal exceptions to your right to confidentiality. I would inform you, if situation permits, of any time when I think I will have to put these into effect. With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA).

**Client initial here: \_\_\_\_\_**

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
2. If I have good reason to believe that you are abusing or neglecting a child, elder adult age 65 and above, or vulnerable/dependent adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services and/or Adult Protective Services.
3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police and/or your local county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team and or police for your safety.
4. If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions.
5. In cases in which I am court-ordered to testify or produce records.

#### **Social Media**

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Instagram, Snapchat, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it. Moreover, if I see you in public outside of the therapeutic office, I will not approach you or acknowledge you to maintain confidentiality.

#### **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 or your situation.

#### **Collaboration with Other Professionals**

In order to provide quality services, I often need to collaborate with other professionals, such as your physician, psychiatrist, past therapists, and/or other mental health professionals. You will be asked to complete a release of information authorizing these exchanges; in some cases, I may not be able to provide services without this.

**Client initial here: \_\_\_\_\_**

**Records and Record Keeping**

I may take notes during session, and will also produce other notes and records regarding your treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Such records are the sole property of the therapist. Should you request a copy of my records, such a 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. I typically maintain records for ten years following termination of therapy. After ten years, your records will be destroyed in a manner that preserves your confidentiality. ***You understand that, by using your insurance, you authorize me to release your clinical information to your insurance company. I will try to keep that information limited to the minimum necessary.***

**Email and Texting**

Use of email may affect the security of messages. For example, using an email app on an unlocked phone may mean that anyone can view messages they receive in that app. Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. Please do not include personal identifying information personal such as medical information in any emails/texts you send to me. No one can diagnose your condition from email or other written communications, and communication via email/text/website cannot replace the relationship you have with your therapist.

**Patient 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 patients' attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in any patient's 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 hourly rate for such services of \$250.00 per hour.

**Therapist Availability / Emergencies**

I am often not immediately available by telephone. You may leave a message for me at any time on my confidential voicemail at 925-567-4268. 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 generally returned within 24 hours during normal workdays. Please understand that as a solo, outpatient practitioner, I am unable to personally provide continuous 24-hour crisis services. In the event of a medical 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. In addition, the national suicide hotline is available 24 hours a day 7 days a week, should you need call the number is 1-800-273-8255.

**Client Initial here: \_\_\_\_\_**

**Psychotherapist-Patient Privilege** The information disclosed by you, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is 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-patient privilege on your behalf until instructed, in writing, to do otherwise by you or your representative. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order. You should be aware that you might be waiving the psychotherapist-patient privilege regarding your entire treatment 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-patient privilege with your attorney.

**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 I determine that you are not benefiting from treatment, either of us 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. It is best to discuss this in a planned termination session if at all possible.

**Acknowledgement:** By signing below, Patient(s) acknowledge that Patient(s) have reviewed and fully understand the terms and conditions of this Agreement. Patient(s) have discussed such terms and conditions with the therapist, and have had any questions with regard to its terms and conditions answered to Patient(s)' satisfaction. Patient(s) agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with the Therapist. Moreover, Patient(s) agree to hold Therapist 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. I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the fee of agreed upon stated above per session. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Dr. Nadieh Kakar, LMFT. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Dr. Nadieh Kakar, LMFT. I am over the age of twelve.

*Patient Printed Name* \_\_\_\_\_

**X** \_\_\_\_\_

*Signature of Patient (or authorized representative)*

*Date*

**(If going through insurance)** I hereby authorize my therapist to bill my insurance carrier or any other payment source. I assign all benefits and authorize payment directly to my therapist for any benefits otherwise payable to me for all claims for such services provided or submitted prior to, or after, the date provided on this form. I understand that I am financially responsible for payment for all services rendered and that I am obligated to pay all charges denied by my insurance carrier. Any assignment and authorization in no way releases me from said responsibility and imposes no obligation on my therapist to collect money on my behalf.

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Name of Responsible Party/Patient (Please print) \_\_\_\_\_ Insurance Name \_\_\_\_\_

**X** \_\_\_\_\_  
Signature of Responsible Party/Patient                      Date                      Date of Birth

### Consent to Treatment of Minors

This section must be completed by the parent or legal guardian of each child who attends session. Some custody agreements require the signatures of both parents for treatment. Because of this, it is generally my policy to require the signature of both parents in any divorce situation. Confidentiality with Minors The State of California provides significant confidentiality to minors seeking mental health treatment. In fact, minors over 12 years of age have many privacy rights similar to those of adults. My role as a therapist is to help minors learn to communicate openly and directly with their parents, and thus, I typically involve parents in the counseling process. That said, when children are making poor and dangerous decisions parents will be brought into the conversation as soon as possible,

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

**Parent / Guardian Name (please print)** \_\_\_\_\_

**Parent / Guardian Signature/ Date** \_\_\_\_\_

**Parent / Guardian Name (please print)** \_\_\_\_\_

**Parent / Guardian Signature/ Date** \_\_\_\_\_