Gayle Plessner, Ph.D
MFT 85032
32107 Lindero Canyon Road Suite #124
Westlake Village, CA 91361
(805) 914-9383
gplessner@gmail.com

INFORMED CONSENT for TREATMENT

This Agreement will provide you with important information regarding the practices, polices and procedures of ***Gayle Plessner, Ph.D*** and to clarify the terms of our professional relationship. If you have any questions or concerns regarding this agreement, please discuss them with me prior to signing this document.

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. Psychotherapy provides an opportunity to improve, and more deeply understand yourself and any problems or difficulties you may be experiencing. Psychotherapy is a joint effort; progress and success depends upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may be uncomfortable. Remembering and discussing unpleasant events and experiences may evoke strong feelings of sadness, anger, and/or fear. There may be times in which you will feel challenged by different perceptions, assumptions, and perspectives. The issues we work through may result in unexpected outcomes, including changes in personal relationships.

During the therapeutic process, many patients find that they feel worse before feeling better. *This is generally expected and a normal course of events*. Personal growth and change can be easy and swift but may also be slow and frustrating. Please address any concerns you might have regarding your progress in therapy.

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice. In order to treat you to my best ability, I may participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, your identifying information will not be revealed.

Records and Record Keeping

I may take notes during session and produce other notes and records regarding your treatment. As these notes constitute clinical and business records required by California law, therapy records are the sole property of this psychotherapy practice and may not be altered in any way from normal record keeping processes. Should you request a

copy of your records, this request must be made in writing. California law states I may provide a treatment summary in lieu of actual records and/or refuse to produce a copy of your records if determined therapeutically harmful. I will provide a copy of your records to another treating health care provider if requested. I maintain records for ten years following termination of therapy, at which time the records will be destroyed in a manner that preserves your confidentiality.

Confidentiality

The information you disclose in session is generally confidential and will not be released to any third party without your written authorization, except where required (court mandated) or permitted by law. ***Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.***

Patient Litigation

As your Therapist, I will not voluntarily participate in any litigation or custody dispute in which you and others are involved. It is my policy to not communicate with attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in legal matters. I will generally not provide records or testimony unless compelled or court ordered to do so. Should I be subpoenaed, or ordered by a court of law to appear on your behalf as a witness or other action pertaining to your involvement, I will ask for reimbursement for time spent preparing, traveling, or other time in which I have made myself available. My fee for participating in legal matters will be discussed at that time.

Psychotherapist-Patient Privilege

Your information and records are subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between myself and you 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 received 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. Please be aware that you might be waiving the psychotherapist-patient privilege if you make your mental or emotional state an issue in a legal proceeding. Please address any concerns you might have regarding the psychotherapist-patient privilege with your attorney.

Fees and Sliding Scale

The fee for individual therapy is ***$150.00 per 50-minute session***. For couples, families and parent conferences, fee is ***175.00 for a 60-minute session.*** I maintain a limited number of appointment times for patients needing a reduced fee. Sliding scale fees are determined upon appointment availability, income and means to pay. ***Sliding scale fees will be reviewed regularly with periodic increases.***

Active credit cards must remain on file, however I accept payment by cash or check at the *beginning* of each session. Please make checks payable to Dr. Gayle Plessner. There is an ATM located in this complex, *so please come to session prepared to pay for your session. I do request a credit card number to be kept on file, should you miss an appointment without cancelling, or forget to bring payment at the time of session. Credit card information is securely stored in your confidential file along with your signed payment authorization form located in this packet.*

NOTICE TO ALL PATIENTS: I do not allow payment balances to exceed two weeks unless prior agreements have been established.

At times, we may engage in telephone contact for purposes other than scheduling sessions***. Telephone calls longer than 15 minutes will incur session fees.*** If telephone contact with third parties is necessary, upon your written and authorized request you will be responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than 15 minutes.

Insurance

I am not a contracted provider with any insurance company or managed care organization. Should you choose to use your insurance, I will provide a statement with the necessary information for you to submit to your insurance company. *Please be aware of your deductible and insurance coverage.*

Cancellation Policy

Your appointment times are protected for you***. You are responsible for cancelling your session. Your session time will remain protected unless I am notified otherwise. Should you need to cancel a session, please notify me 24 hours in advance. If you miss a session without advanced notification me you will be charged full fee for the missed session.*** Confidential voice mail: **(805) 914-9383.**

Therapist Availability

You may leave me a message at any time. I will make every effort to return your call within 24 hours (or by the next business day). *I do not provide 24-hour crisis service.* ***In the event that you are feeling unsafe or require immediate medical or psychiatric***

assistance, do not hesitate to call 911, or go to your nearest emergency room.

Termination of Therapy

If necessary, I may terminate therapy if I determine that sessions are no longer in your best interest. Reasons for termination include, but are not limited to, repeated occurrences of late payments, an unwillingness to comply with agreed upon treatment recommendations, conflicts of interest, a resistance to participate in therapy, or psychological needs extend beyond my scope of competence or practice. You have the right to terminate therapy at your discretion for these circumstances as well. If termination ensues, I will recommend that you participate in at least one, or possibly more termination sessions. These sessions are intended to facilitate a positive separation in order to provide an opportunity to reflect on the work that has been done. I will attempt to ensure a smooth transition to another therapist by offering qualified referrals.

Please continue to next page for signatures

Acknowledgement by Signatures

My signature acknowledges that I have reviewed and *fully understand* the terms and conditions of this agreement. I am aware I may discuss terms and conditions with my therapist, I agree to abide by the terms and conditions of this agreement and I consent to participate in psychotherapy. My signature verifies that I hold Gayle Plessner, Ph.D free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from our therapeutic work together.

_____

Patient Name (please print)

_____ _____

Signature of Patient Date

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by any other third-party payor.

_____ _____

Name of Responsible Party Date

_____ _____

Signature of Responsible Party Date

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Patient Information

Referred by: _____

Name of Patient: _____ DOB _____

Address: _____

City _____ State _____ ZIP _____

Home PH: (____)_____-_____ Cell: (____)_____-_____ Wk: (____)_____-_____

Email: _____

Patient's Occupation: _____

Patient's Workplace: _____

Work Address: _____

Spouse/Partner Name: _____

Home PH: (____)_____-_____ Cell: (____)_____-_____ Wk: (____)_____-_____

Person responsible for payment (Please Print):

_____

DL# and State: _____

Address (if different from above):

_____

City: _____ State: _____ ZIP: _____

Other person(s) residing in Home (children, ext. family members, others):

_____ Age: _____ Relationship: _____

_____ Age: _____ Relationship: _____

_____ Age: _____ Relationship: _____

_____ Age: _____ Relationship: _____

Physician Name: _____

Physician Phone: (_____)_____-_____

Medication(s), dosage: _____

_____

_____

Prescriber's Name: _____

Prescriber's Phone: _____

Prescriber's Address: _____

Emergency Contact (Please Print Clearly):

_____

Emergency Phone : (_____)_____-_____

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Authorization to Exchange Confidential Information

I, [Name of Patient] _____ authorize Gayle Plessner, Ph.D to exchange confidential information regarding my treatment with [name and function of person to which information is to be exchanged]

_____

This Authorization permits the exchange of the following information:

____ Any and All Information Necessary

____ Diagnosis ____ Progress to Date ____ Patient Records ____

____ Treatment Plan ____ Prognosis ____ Clinical Test Results ____

Information limited to: _____

This Authorization shall remain valid until: _____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing

_____ _____

(Patient or Patient's Representative*) Date

*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative

Credit Card Authorization Form

I understand that this authorization is valid until canceled in writing. I understand this information is secured in a locked, protected patient file. I agree to assume the risk in the unlikely event this file and/or account is tampered with and credit card information is compromised. **I understand that charges for missed sessions not cancelled within the agreed upon 24-hour cancellation period or non-payment at time of session** *will be posted to my credit/debit account within 48 hours of each session date and* ***session fee will be charged on the day of my session.*** Additionally, I agree that the card listed below may be charged by my therapist in order to settle outstanding balances. I am responsible for charge back fees or retrieval fees.

Initial _____

I agree that if I have any concerns or questions regarding charges to my account, or if charge fails to post to my account, I will contact my therapist for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with my therapist and those attempts have failed.

Initial _____

If I am assuming responsibility for session payment of a Patient other than myself, I understand that *I am not entitled to information pertaining to confidential therapy sessions* as provided by Gayle Plessner, Ph.D.

Initial _____

My signature confirms that I understand and agree to these terms, understand the conditions of this payment policy and agree to the conditions stated above:

Cardholder Name [print]: _____

Signature _____

Relationship to Patient: _____

Credit Card Billing Address: _____

City: _____ State: _____ ZIP CODE: _____

Card Type: _____

Acct. Number: _____

Security Code: _____ Exp. Date: _____

I understand that my therapy sessions will be charged via this form and not by swiping my card on the morning of my session.

_____ _____

Cardholder Signature **Date**