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

AGREEMENT FOR COUPLES PSYCHOTHERAPY / INFORMED CONSENT

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 therapeutic relationship. Any questions or concerns regarding this agreement should be discussed with me prior to signing it.

Risks and Benefits of Therapy

Couples Psychotherapy is a process in which we will discuss a myriad of marital/partner and individual issues, events, experiences and memories for the purpose of creating positive change. Psychotherapy provides an opportunity to improve, and more deeply understand your relationship and yourself and any problems or difficulties your relationship may be experiencing. Psychotherapy is a joint effort; progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may involve some discomfort including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which you will feel challenged by alternative perceptions, assumptions, and different perspectives. The issues you present as a couple may result in unintended outcomes, including changes in your relationship.

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

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice. As such, 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 couples treatment. As these notes constitute clinical and business records required by California law, such 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 a couples 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.***

No Secrets Policy

Often times, patients may be seen individually to help inform couples session. ***Information revealed in individual sessions may be revealed in couples sessions if the information is pertinent to couples therapy. The revealing of information not pertinent to couple sessions will be left to the discretion of the therapist. Patients revealing issues concerning infidelities when seen individually will be encouraged to share these issues in couples session, unless the relating of such information is determined to cause serious physical harm to either parties.***

Patient Litigation

As your Therapist, I will not voluntarily participate in any litigation, or custody dispute in which the couple is a party to. 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 for such an appearance at the usual and customary hourly rate of $150.00.

Psychotherapist-Patient Privilege

Couples information and records are 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, 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.

Fee and Fee Arrangements

The usual and customary fee for couples therapy is ***$ 175.00 for a 60-minute session***. Sessions longer than 50-minutes are charged for the additional time pro rata.

Sliding Scale Fees

I utilize sliding scale fees if appropriate; ***sliding scale fees will be reviewed regularly with periodic increases.***

Sliding scale fees will be reviewed upon couple's decision to change from weekly to bi-monthly appointments.

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

At times, we may engage in telephone contact for purposes other than scheduling sessions. Couples are responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, if it is necessary to engage in telephone contact with third parties at your written and authorized request couples will be responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes.

An active credit must remain on file. **At the beginning of each session**, payment by cash or check (made payable to Gayle Plessner, Ph.D is the preferred method of payment. 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.*

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 you can submit to your insurance company. *Please be aware of your deductible and insurance coverage.*

Cancellation Policy

Your appointment times are protected for you and will remain so until otherwise notified. 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

Couples 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), but I cannot guarantee a call will be returned immediately. *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 discern that sessions are not 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. Couples have the right to terminate therapy at their discretion for these circumstances as well. If termination ensues, I will generally recommend that you participate in at least one, or possibly more termination sessions. These sessions are intended to facilitate a positive separation.

Acknowledgement by Signatures

Our signature acknowledges that we have reviewed and *fully understand* the terms and conditions of this agreement. We are aware we may discuss terms and conditions with my therapist. We agree to abide by the terms and conditions of this agreement and consent to participate in psychotherapy. Our signature verifies that we 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. Our signatures verify we accept responsibility for payment.

_____

Patient Name (please print)

_____

Patient Name (please print)

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient Date

Gayle Plessner, Ph.D

Licensed Marriage and Family Therapist # 85032

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Couple's (Patient 1) 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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Couple's (Patient 2) 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**