ALLISON D. OSBURN-CORCORAN, M.A., MFT
LICENSE NO. LMFT52602
LICENSED MARRIAGE AND FAMILY THERAPIST
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AGREEMENT FOR PSYCHOTHERAPY SERVICES AND INFORMED CONSENT

This Agreement is intended to provide you with important information regarding the practices, policies and procedures of this office and to clarify the terms of the professional therapeutic relationship. If you have any questions or concerns regarding the contents of this Agreement, please ask your therapist prior to signing this Agreement.

License Status:

Allison D. Osburn-Corcoran, MFT is a Licensed Marriage and Family Therapist. Ms. Osburn-Corcoran has been licensed by the California State Board of Behavioral Sciences (Lic# LMFT52602).

Statement of Confidentiality:

I understand that the information I disclose is generally confidential and will not be released to any third party without written authorization, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, reporting child, elder and dependent adult abuse, when a client makes a serious threat of violence towards a reasonably identifiable victim, or when a client is dangerous to him/herself or the person or property of another. In addition, a federal law known as **The Patriot Act of 2001** requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and **prohibits** the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

If I participate in marital or family therapy, I understand that my therapist will not disclose confidential information about my treatment unless all person(s) who participated in the treatment with me provide their written authorization to release such information. However, I understand that my therapist utilizes a “no-secrets” policy when conducting family or marital/ couples therapy. This means that if I participate in family, and/or marital/couples therapy, my therapist is permitted to use information obtained in an individual session that I may have had with her, when working with other members of my family.

If my child is the client, I understand that psychotherapy can only be effective if there is a trusting and confidential relationship between the therapist and my child. I understand that I will be kept up to date as to my child’s progress in therapy, but I will not be privy to detailed discussions between them. However, I can expect to be kept informed in the event of any serious concerns the therapist may have regarding the safety or well-being of my child, including suicidality.

Psychotherapist-Patient Privilege:

I understand that the information disclosed, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between the therapist and the 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. I understand that if my therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, my therapist will assert the psychotherapist-patient privilege on my behalf until instructed, in writing, to do otherwise by a person with the authority to waive the privilege on my behalf. If the patient is my child, the holder of the psychotherapist-patient privilege is my child, a court-appointed guardian, or my child’s counsel. Parents do not typically have the authority to waive the psychotherapist-patient privilege for their minor children, unless given such authority by a court of law. If I have any concerns regarding the psychotherapist-patient privilege, I should discuss this with my attorney.

Policy Regarding Consent for the Treatment of a Minor Child:

I understand that the therapist generally requires the consent of both parents prior to providing any services to a minor child. If any question exists regarding my authority to give consent for psychotherapy, I may be required to submit supporting legal documentation, such as a custody order, prior to the commencement of services.

I further understand that the therapist will not voluntarily participate in any litigation or custody dispute involving me or my child as parties, will not make any recommendation as to custody or visitation regarding my child, and will not be involved in any custody dispute involving my child. My therapist **is not qualified, nor does she conduct, either formal or informal child custody evaluations.**

Records and Recordkeeping:

I understand that my therapist may take notes during session, and will also produce other notes and records regarding my treatment. These notes constitute the therapist's clinical and business records, which by law, the therapist is required to maintain. Such records are the sole property of the therapist. Should I request a copy of these records, I must make this request in writing. I understand that the therapist reserves the right, under California law, to provide me with a treatment summary in lieu of actual records. I also understand that the therapist reserves 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 healthcare provider. I understand that the therapist will maintain my records for a minimum of ten years following termination of therapy (or for a minor, a minimum of 10 years after reaching the age of 18). However, after ten years, my records may be destroyed, and if so, will be destroyed in a manner that preserves my confidentiality.

Risks and Benefits of Therapy:

I understand that psychotherapy is a process in which my therapist and I discuss a myriad of issues, events, experiences, and memories for the purpose of creating positive change so that I can experience my life more fully. It may result in a number of benefits to me, 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 a substantial effort on my 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.

I understand that participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings, and experiences, and evoke strong feelings of sadness, anger, fear, etc. There may be times that the therapist will challenge my perceptions and assumptions, and offer different perspectives. The issues that I present in therapy may result in unintended outcomes, including changes in personal relationships. I am aware that any decision on the status of my personal relationships is my responsibility.

I understand that during the therapeutic process, I may feel worse before I feel better, which 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. I understand that I should address any concerns I have regarding my progress in therapy with my therapist.

Voice Mail and Emergencies:

I understand that I can leave a message for my therapist at any time on the voice mail system. Routine phone calls will be returned within 24 hours, between the hours of 9:00 am and 8:00 pm Monday through Friday. As a general rule, my therapist does not return routine calls on Saturdays, Sundays or on holidays. For maximum therapeutic effectiveness and to ensure confidentiality, telephone contacts are for arranging and changing appointment times and for emergencies only. In case of an emergency, please follow the instructions stated on the voicemail recording. In the event that I am feeling unsafe or require immediate medical or psychiatric assistance, I should call 911 or go to the nearest emergency room. I understand my therapist may utilize electronic mail (e-mail) solely for the purposes of scheduling or printing off forms.

Payment, Fees, and Cancellation Policy:

I understand that payment is due when the service is rendered. Fees for additional services such as extended telephone conversations, consultations with others (insurance companies, physicians, teachers, etc.), inpatient hospital visits, psychological testing, etc., will be based on the nature and extent of the service in accordance with the session rate. I understand that this will be discussed with me prior to the service. NOTE: There is a $25.00 charge for any returned check.

I understand that my appointment time has been reserved for me. **Therefore, I understand that I am responsible for payment for any sessions that I fail to give at least 24 hours notice of cancellation, or any session that I miss**. I am aware that I can leave a message on my therapist's voice mail at any time, day or night, and it will record the day and time of my call.

Termination of Therapy:

I understand that I have the right to terminate therapy at any time. I also understand that my therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination may include, but are not limited to, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, my needs are outside the therapist's scope of

competence or practice, I am not making adequate progress in therapy, or untimely payment of fees. I understand that should either my therapist or I decide to terminate therapy, I may be asked to participate in at least one, or possibly more, termination sessions in order to facilitate a positive termination experience and give us both an opportunity to reflect on the work that has been done. I also understand that my therapist will attempt to ensure a smooth transition to another therapist by offering referrals to me.

Acknowledgment:

By my signature below, I certify that I have reviewed the information and have been given the opportunity to ask questions and have them answered. I fully understand the information contained in this document. I agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with my therapist. Moreover, I agree to hold my 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 been given a copy of this document for my own records.

Dated: ____________________, 20____

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Client Name (please print)

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Signature of Client (if Client is 12 or older)

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Signature of Representative (and relationship to minor)

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Signature of Representative (and relationship to minor)