Anna Lindberg Cedar, MPA, LCSW # 64284

OFFICE POLICIES and CONSENT FOR TREATMENT

WELCOME TO MY COUNSELING PRACTICE. I look forward to working with you. The following document is designed to give you information about my professional services and business policies. Please read this carefully. If you have any questions or concerns, please ask me at your first session, or as soon as they arise during the course of treatment. Please note that when you sign this form it represents an agreement between us.

PROCESS OF THERAPY: Participating in therapy can result in a number of benefits including improvements in self-esteem, relationships, health, life satisfaction and specific problem areas for which you are seeking help. Working towards these goals, however, requires ongoing effort on your part, and at times may result in uncomfortable feelings such as sadness, anxiety, or anger, as well as joy and relief. Relationships with significant others may also change as a result of being in therapy because of changes in how you feel, communicate, relate and deal with conflict. Feelings may also arise in relation to the therapist and the therapy process. Please feel free to discuss any feelings or problems you may have regarding the therapy or to ask any questions about my approach or about your progress towards your therapeutic goals. If you begin to think about ending therapy, I encourage you to discuss your feelings about wanting to do this with me so they can be addressed. If you do decide to end therapy, you may request for me to provide you with referrals to other qualified professionals.

CONFIDENTIALITY: In general, all communication between a therapist and a client is confidential and protected by law and may not be revealed without your written permission. Confidentiality also protects children and adolescent clients. There are a few exceptions in which I am legally obligated or permitted to break confidentiality. Please review these exceptions carefully and ask me any questions at your first session or as soon as they arise during the course of treatment.

1. Disclosure is required when there is reasonable suspicion of child abuse/neglect, and dependent adult and elder abuse.
2. If a client is a serious, imminent danger to others, I am required to take protective measures. This would include notifying a potential victim, and the police.
3. If my client threatens to harm him/herself, I have the permissive right to seek hospitalization or contact family members or others who can provide protection.
4. The Patriot Act designates that FBI agents have the right to obtain information from therapists that pertain to National Security.
5. In most – but not all – legal proceedings, you have the legal right to prevent me from giving information about your therapy. In certain legal situations, such as in a child custody case or when your emotional condition is an issue (for example, in a Worker's Compensation or personal injury case), the judge may order me to testify. (Continued…)

Initials: _____

When therapeutically indicated, I will make every reasonable effort to discuss my course of action with you prior to breaking confidentiality. If you are participating in group therapy, details of the group are to be kept strictly confidential (please see separate forms for more information about group therapy). On occasion, it may be beneficial to your situation to consult other professionals about your case. During such a consultation, I make every effort to protect your identity. The consultant is also legally obligated to keep the information confidential.

CONFIDENTIALITY WITH FAMILY AND COUPLES THERAPY: When working with family members and couples, I will ask all parties to sign releases of information so that I may share relevant information and give important feedback to all those participating in treatment. In situations where *one* family member or *one* partner requests that I release information about the family or couples sessions, it is my policy not to release information unless all family members (or both members of the couple) sign an authorization allowing me to do so.

APPOINTMENT AND CANCELLATIONS: My appointments run for 50 minutes. Since the scheduling of an appointment involves reservation of a time set aside specifically for you, a 24 hour notice is required for rescheduling or cancelling an appointment. If for any reason, other than emergency, a session is cancelled less than 24 hours in advance, you will be charged for the full amount of the session.

PAYMENT AND INSURANCE: My fee for individual therapy is $150.00. Payment is due at each session, unless other arrangements are made. I am not currently contracted with any insurance companies and patients pay me directly. However, if you have a PPO insurance plan, you will likely have "out-of-network" benefits, which means that visits may be at least partially reimbursed. I recommend that you call your insurance or look into your insurance policies to determine procedures for mental health reimbursement. Your fee has been set at _____ and will be reassessed periodically.

TELEPHONE AND OTHER PROFESSIONAL CONSULTATIONS: Phone calls that are less than ten minutes in length will not be charged. However, for those calls that are more than ten minutes, they will be charged at quarter-hour segments (based on your established fee). For professional consultations with people with whom you have asked or allowed me to speak (physicians, attorneys, schoolteachers, therapists, etc.), I charge in quarter-hour segments (for calls that are more than ten minutes). I also charge for time writing letters/reports about your case, reading extensive reports, and for photocopying files. I will notify you about these charges before beginning these activities. These are charges that insurance companies usually do not cover. If you become involved in legal proceedings that may require my participation, you will be expected to pay for my professional time even if I am called to testify by another party.

TERMINATION OF TREATMENT: You have the right to terminate treatment at any time. However, if you are dissatisfied with my services or have questions about my treatment methods, I invite you to discuss them with me as soon as possible. If you decide to stop treatment with me, I will be happy to give you the names and telephone numbers of other therapists in order to ensure a smooth transition

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Initials: _____

of your care. Therapists also have the right to terminate therapy under certain circumstances – for example, if a client is not benefiting from treatment after a reasonable length of time or if a client could benefit more from receiving treatment elsewhere. At times, during the course of treatment, additional issues come to light that would best be addressed by another therapist or treatment agency which specializes in that particular area. In the event that it becomes apparent that it is in your best interests to terminate treatment with me, referrals will be given and reviewed carefully with you. In addition, I will conduct termination sessions with you prior to your transfer to another therapist or treatment facility.

EMERGENCIES: To contact me between sessions, you may leave a message on my confidential voice mail (510) 984-3360 and I try will return your call within 24 hours or on the next business day. If an emergency situation arises call 911 or go to the nearest hospital. For additional support with urgent psychological needs, you can contact the Alameda County mental health linkage line at **1-800-494-9099** (http:// www.acbhcs.org). You may also reach a national suicide prevention hotline by calling: **1-800-273-8255**. I recommend that my clients preprogram this information into their phone so that they have it available in a moment of need.

CONSENT FOR TREATMENT: My signature on this page indicates that I am consenting to enter into treatment with Anna Lindberg Cedar, MPW, LCSW # 64284, and that I am authorizing this practitioner to conduct diagnostic procedures, psychological assessments, and treatment procedures throughout my course of treatment. It is my understanding that the purpose and rationale of these procedures will be explained to me and that they are subject to my agreement. I also understand that the outcome of my treatment cannot be guaranteed, even though psychotherapy is designed to be helpful (for more information, please see Page 1, Paragraph 2, “The Process of Therapy”).

I UNDERSTAND AND AGREE TO THESE POLICIES AND GIVE MY CONSENT TO TREATMENT.

_____

PRINTED NAME

_____ _____

SIGNATURE **DATE**