

Beth Kanne-Casselmann, MEd, MFT
805-895-6960

Marriage Family Therapist

License # MFC 41818

NPI# 1952634149

EIN# 27-1572016

5266 Hollister Avenue Suite 233

Santa Barbara, California 93111

INFORMED CONSENT FOR THERAPY SERVICES

THERAPIST QUALIFICATIONS & APPROACH

I am a Licensed Marriage and Family Therapist committed to providing professional services to help you achieve your therapeutic goals. Therapy is a collaborative partnership requiring your active participation, honesty, and willingness to change thoughts, feelings, and behaviors.

FEES & PAYMENT

- **Session Fee:** \$225 for all individual, couples, and family therapy sessions
- **Session Length:** 50 minutes (adults), 45 minutes (children 3-16)
- **Payment:** Due at time of service (credit card payments using Ivy Pay, cash or check accepted)
- **Court Appearances:** \$5,000/day if subpoenaed
- **Communication:** Email/phone calls charged after first 15 minutes
- **Insurance:** Super-bills provided upon request for reimbursement
- **Fee Changes:** 60-day advance notice provided
- **Good Faith Estimate:** Available upon request as required by law

SCHEDULING & CANCELLATIONS

- Sessions typically scheduled weekly at consistent times
- **24-hour cancellation notice required** to avoid full session charge
- Regular attendance essential for therapeutic success
- Frequency may be adjusted based on clinical needs

Initial here to acknowledge cancellation policy: _____

CONFIDENTIALITY & PRIVACY

All communications are strictly confidential except when legally required to disclose:
Mandatory Reporting Requirements:

- Suspected child, elder, or dependent adult abuse/neglect
- Imminent danger to self or others
- Court-ordered testimony or legal proceedings involving your psychological state
- FBI requests under The Patriot Act

Additional Disclosures:

- Professional consultations (your identity protected)
- Family therapy: information shared only with written consent of all participants ●
Minors (12+): communications confidential but parents may be involved in treatment decisions
- Children under 12: brief email updates and periodic parent meetings provided ●
Please read the HIPAA information shared with you and be sure to ask any questions prior to signing this agreement

COMMUNICATION & TECHNOLOGY

Contact Preferences:

- Phone: _____ (OK to call? Y/N)
- Email: _____ (OK to email? Y/N)

Important Limitations:

- Electronic communications (email, text, telehealth) are **never 100% secure** ●
By using these methods, you consent to their inherent privacy risks ●
Emergency services: Call 911 or go to nearest emergency room
- Non-urgent calls returned within 24-48 hours during business days

Initial here to acknowledge communication risks: _____

TELEHEALTH SERVICES

- HIPAA-compliant platforms used but technology risks remain
- Identity and location verification required each session
- **No recording of sessions permitted**
- Client responsible for private, secure environment
- Risk of technical failures or unauthorized access exists

THERAPY PROCESS & OUTCOMES

Potential Benefits: Reduced stress/anxiety, improved relationships, increased self-confidence, better coping skills, and many other benefits we can discuss

Potential Risks: Temporary discomfort, difficult emotions, relationship changes, no guarantee of specific outcomes

Important Notes:

- Progress varies by individual and level of participation
- You may feel worse before feeling better, especially with trauma work ● I am available to you as soon as I can respond to your outreach if you need anything ●
- Therapist-client fit is crucial; referrals provided if needed
- Either party may terminate therapy with appropriate notice

SOCIAL MEDIA & BOUNDARIES

- No social media connections with current or former clients
- Strict professional boundaries maintained during and after therapy
- No dual relationships outside therapeutic context

RECORDS & DOCUMENTATION

- Clinical records maintained as required by law
- Records stored securely on HIPAA-compliant electronic systems
- Treatment summary may be provided instead of full records
- Records retained 7 years post-treatment (or until age 25 for minors)
- Records then destroyed in confidential manner

EMERGENCY RESOURCES

- **911 or nearest emergency room for immediate crises**
- Santa Barbara County Mental Health: 805-884-1650
- National Suicide Prevention Lifeline: 988
- California Warm Peer Line: 855-845-7415
- National Domestic Violence Hotline: 1-800-799-7233
- Trevor Project (LGBTQ+): 1-866-488-7386
- Trans Lifeline: 1-877-565-8860

COMPLAINTS & GRIEVANCES

Discuss concerns directly with me first. For formal complaints: **Board of Behavioral Sciences**
www.bbs.ca.gov | (916) 574-7830

ACKNOWLEDGMENT & CONSENT

Client Information:

- Name: _____
- Date of Birth: _____
- Address: _____
- Best Phone: _____

For Minors:

- Minor's Name: _____
- Date of Birth: _____
- Parent/Guardian: _____

By signing below, I acknowledge that I have read and discussed as needed, understood, and agree to the terms outlined in this informed consent and the HIPAA: Notice of Privacy Practices and Good Faith Estimate prior to signing this form.

I understand my rights and responsibilities as a client, and I consent to treatment for myself or my minor child.

Minor Signature (if 12+): _____ Date: _____

Adult/Parent Signature: _____ Date: _____

Additional Parent/Guardian: _____ Date: _____

Therapist Signature: *Beth Kanne-Casselmann LMFT* Date: _____

ADDENDUM: CAREGIVER'S AUTHORIZATION AFFIDAVIT

This must be completed by the parent/s or guardian/s of any minors.

Instructions: Completion of this affidavit are sufficient to authorize enrollment of a minor in treatment with Beth Kanne-Casselmann, Licensed Marriage & Family Therapist (#MFC41818).

Initials: _____

I am authorizing Beth Kanne-Casselmann to work with the minor named below.

1. Name of the minor:

2. **Minor's birth date:**
3. **My name (adult giving authorization):**
4. **My home address:**
5. **My relationship to the minor:**
6. **My date of birth:**
7. **My California driver's license or identification card number:**

WARNING: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both. I declare under penalty of perjury under the laws of the state of California that the foregoing is true and correct.

Date:

Print and sign full legal name:

Additional Information:

1. This declaration does not affect the rights of the minor's parents or legal guardian regarding care, custody, and control of the minor, and does not mean that the caregiver has legal custody of the minor.
2. A person who relies on this affidavit has no obligation to make any further inquiry or investigation.
3. **This affidavit is not valid for more than one year after the date on which it was executed.**

To the Health Care Provider:

1. No person who acts in good faith reliance upon a caregiver's authorization affidavit to provide care/treatment, without actual knowledge of facts contrary to those stated on the affidavit, is subject to criminal liability or to civil liability to any person, or is subject to professional disciplinary action, for such reliance if the applicable portions of the form are completed.
2. This affidavit does not confer dependency for health care coverage purposes.