INFORMED CONSENT FOR THERAPY SERVICES

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INTRODUCTION & THERAPIST QUALIFICATIONS

This document provides important information regarding our working together. Please read it carefully and ask any questions about its contents.

You are free to ask questions at any time about my background, experience, and professional orientation. I am a Licensed Marriage and Family Therapist, License #MFC41818. I believe we are partners in the therapeutic process.

Please initial in the two spaces provided and sign this at the conclusion once any questions have been addressed about this consent.

If the client is a minor, there is an addendum at the end of this document that must be completed and signed by the parent/s/caregiver/s.

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 (Ivy Pay HIPAA compliant credit card platform, 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 are 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
- Private communications between family members require written permission to share
- Release of Information (ROI) may be requested if you are seeing another therapist
- Minors (12+): communications confidential but parents may be involved in treatment decisions per my professional judgment
- Children under 12: brief email updates and/or joint meetings every 6-8 sessions (adults alone or with minor)
- Communication and updates from parents and caregivers, including questions, observations, concerns, or feedback are welcome at anytime

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

My Approach: I intend to provide services that assist you in reaching therapeutic goals. Based on the information you provide and your specific situation, I will make treatment recommendations. Due to the varying nature and severity of issues and individuality of each patient, I cannot predict therapy length or guarantee specific outcomes. Sessions are typically weekly, every other week sessions are generally not scheduled, but are considered appropriate at times. You are legally entitled to a Good Faith Estimate and I will provide this upon your request.

Potential Benefits: Reduced stress/anxiety/situational depression, improved relationships, increased self-confidence, better coping skills, more secure relationships, emotional regulation, skills and tools for managing discomfort, deepening self awareness, improved communication, conflict and repair, and somatic relief…

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
- Therapist-client fit is crucial; referrals provided if needed
- Either party may stop therapy; discussion of treatment alternatives available if not benefiting

- Active participation, honesty, and willingness to change are essential for success

COMPLETION OF THERAPY

The length and timing of treatment completion depends on your unique situation and goals. It is advisable to plan for ending therapy in collaboration with me. We will discuss an ending plan as you approach completion of treatment goals or desire to make a change. You may discontinue therapy at any time. If either of us determines you are not benefiting from treatment, we may discuss alternatives.

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

Please discuss concerns directly with me first.

For formal complaints: **Board of Behavioral Sciences**
www.bbs.ca.gov | (916) 574-7830

ACKNOWLEDGMENT & CONSENT

For Minors:

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

Your signature indicates that you have read this agreement for services carefully and understand its contents. Please ask me to address any questions or concerns about this information before you sign it.

Printed Name(s) and Signature(s) of Patient(s):

Name: Date:

Name: Date:

Name: 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-Casselman, Licensed Marriage & Family Therapist (#41818).

Initials: _____ I am authorizing Beth Kanne-Casselman 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.
