TIANA BEARD THERAPY

INFORMED CONSENT FOR THERAPEUTIC SERVICES

3150 Hilltop Mall Rd
Suite 12
Richmond, CA 94806
510.859.4704

This document contains important information about my professional services and business policies and how they may affect you. Please read it carefully and jot down any question you'd like to discuss with me. By initialing and signing this document, it becomes a binding agreement between us and will also act as the consent you give me to provide you therapeutic services.

What to Expect From Treatment

Participating in therapy can help you learn new and important things about yourself and others as well, as new and better ways of handling feelings or problems. While there are no guarantees, engaging in therapy should help you feel better and produce beneficial results. You know therapy is working when you feel you are making progress towards your goals. Sometimes you may feel worse before you feel better. This is a part of the therapeutic process and usually means you are making progress. You have the right to end therapy at any time.

Voluntary Relationship

Our therapeutic relationship is strictly voluntary. At any time during our work together, you have the right to decide to end treatment. If you are thinking about ending therapy, I encourage you to discuss it with me, and if you wish, I will be glad to provide you with referrals to other providers. During the course of therapy if I assess that I am ineffective in helping you reach your therapeutic goals, I will discuss this with you, and if appropriate, terminate treatment.

Fees and Payment

Your session fee is $_____. Payment is expected at the beginning of each session. Cash or credit/debit card is the preferred method of payment. If you would like to use your credit card as a method of payment, please complete the credit/debit authorization form. Session fees are subject to change. You will be notified at least 28 days prior to such changes.

Occasionally, I may engage in telephone contact with you for purposes other than scheduling sessions. For any telephone calls that are longer than 15 minutes, you may be charged a full or pro-rated fee, in which you are responsible for the payment of the agreed upon amount. In addition, I may engage in telephone contact with third parties at your request and with your advance written authorization. These third-party contacts can also result in a full or pro-rated fee if they take longer than 15 minutes. Also, if you request a letter or documentation of attendance in therapy that requires a significant time investment, I may charge for the time at the same rate as your regular fee. If you ever have difficulties with your bill, please discuss your finances with your therapist as soon as possible. By your initial on this page, you agree that you are financially responsible to Tiana Beard, LMFT for all charges.

Insurance Reimbursement

If applicable, client shall check with their insurance company to determine whether mental health coverage is available, the amount of the annual deductible and if any additional documentation is required before the insurance company will reimburse any or all therapy costs. The client is responsible for payment of all therapy charges at the time of service or unless a separate written agreement for insurance reimbursement has been signed with the therapist. Upon request following payment, the therapist will provide a receipt that can be submitted to the insurance company for reimbursement. If the insurance company requires the therapist to complete forms, the therapist will submit these as soon as reasonably possible to facilitate payment.

Session Times, Cancellations, and Rescheduling

The average length of a session is between 45 and 50 minutes. Sessions are held weekly, unless other arrangements have been made and agreed upon by both you and Tiana Beard, LMFT. If you arrive late to your session, please note that the session will still end at the regularly scheduled end time. In order for therapy to be effective, it is important for sessions to be attended on a consistent and timely basis. Excessive cancellations can lead to ineffective treatment and create a barrier to progression in the therapeutic relationship.

If you need to cancel or reschedule a session, please notify me at least 24 hours in advance of our scheduled meeting or you will be responsible for full payment for the session. There is no guarantee that I can reschedule you for a different time during the week, in the event that this is the case, you are still responsible for the full payment of the session if you cannot make the originally agreed upon session time. The card you provided on the payment authorization form will be charged on the day of the missed session if 24-hour notice was not provided. Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements

have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

Contacting me

You may contact me at 510-859-4704, though I am often not immediately available. I cannot guarantee but will try my best to reach you within 24 hours of your phone call. Please refer to the emergency section of this document to see information on who to call if you need assistance on days in which I am unavailable.

Time Away From the Office

There are times throughout the year that I will be away from the office and will not be available to you. You will be notified of any vacations or time away from the office that I plan to take in advance. If I take an extended period of time off, and you feel that you will need services during that time, I will assist you in finding another therapist through providing you with referrals.

Email/Text Usage

Therapy is confidential. You can have the confidence that your insights, vulnerable experiences, and feelings will not be repeated outside the therapeutic relationship and what we have agreed upon regarding limits to confidentiality and/or signed releases of information. However, there are some forms of communication in which confidentiality is not guaranteed.

Emails or text messaging correspondence is NOT confidential. Though Internet and phone security measures can be effective, it is never 100% seal proof. My policy regarding email usage is as follows:

• Email and/or text correspondence with me is NOT secure.

• Email and/or text correspondence is NOT a substitute for person-to-person therapeutic treatment.

• Email and/or text correspondence will not play a part in your therapy.

• I will not provide detailed responses to your emails and/or text. Important information, aside from scheduling or rescheduling sessions, will be discussed or relayed in session. In the event that a face to face session is not possible, information will be relayed through a phone conversation or voicemail.

• Email and/or text correspondence is NOT to be used in the case of an emergency to contact me. If you cannot reach me directly by a phone conversation, please call 911 or go to the emergency room.

Emergencies

If you are experiencing a life-threatening emergency and need to talk to someone immediately, you can call 911, your local police department, or visit your local hospital emergency room. You can also contact the Suicide Prevention Hotline at (800) 273-TALK (8255) or Contra Costa County crisis support services at 1-800-833-2900. All of the above references are available 24 hours a day, 7 days a week.

Privilege and Confidentiality

Confidentiality is a foundation of the therapist-client relationship. It is important to know that the law protects confidential communications between a client and their therapist. The protection, known as a "privilege," applies to any confidential communication between therapist and client (e.g. anything you tell the therapist during sessions or what you might text or email them) or information that your therapist obtains about you during professional consultation. You, as the client, hold the privilege. This means that your therapist cannot share your confidential information (whether verbal or written) with anyone else unless you, the client, consent to the disclosure.

There are, however, certain limited exceptions to the privilege, wherein a therapist may break confidentiality, or is required by law to break confidentiality, and disclose client information. If this becomes the case, your therapist will make every reasonable effort to discuss this with you, before such disclosure, unless prohibited by time, urgency or the law. These exceptions include, but are not limited to the following: • Child Abuse, Elder Abuse, or Dependent Adult Abuse: Therapists are mandated by law to report cases of suspected child abuse (of children and youth under age 18), elder abuse (of adults over age 65), or dependent adult abuse (adults between the age of 18 and 64) to the appropriate authorities.

• Suicide: If you are in imminent danger of killing yourself, your therapist will need to breach confidentiality in order to keep you safe. This may include informing your family member(s) or taking action to see that you are admitted to a hospital.

• Homicide: If you disclose to your therapist that you are planning to kill or hurt someone, they are required by law to inform the police, inform your intended victim(s), and inform any other necessary individuals in order to prevent loss of life.

• As Mandated by Law: For example, if your therapist receives a subpoena, they may be required to submit your records as part of a legal proceeding.

Limits on the Intent of Treatment

I do not engage in treatment services for the purpose of custody evaluations, immigration evaluation, disability evaluation, mediating divorce/separation disputes or for the purpose of making recommendations regarding employment, disability, placement, and custody or caregiver competency. If you have concerns or questions about any of these topics, please address this with me immediately. You will be given referrals to qualified providers who are more experienced at handling these issues and who can better assist you with your needs.

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice and I regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, there might be discussion of the content of your therapy, but no personally identifying client information will be revealed. With your consent, I may videotape your sessions, in order to assist with therapy, for supervision/consultation purposes or for training and education purposes.

Please select your response: I do• do not• consent to having my sessions recorded for supervision/consultation.

I do• do not• consent to having my sessions recorded for training/education purposes.

Record Keeping

The laws and standards of the profession require every therapist to keep treatment records. These may include information about your diagnosis, therapy goals, progress in treatment, documentation of mandated disclosures (e.g., report of child abuse), and other information. You have a right to view your records or receive a treatment summary by making a request in writing. Under California law, the therapist reserves the right to provide a treatment summary or to refuse to produce a copy of the record, under certain circumstances where the therapist believes that doing so would be likely to cause you substantial harm, endanger your life or physical safety, or pose a significant risk of harm to another individual. Therapist will maintain an adult client's records for seven years following termination of therapy or as required by law. However, after seven years (or the required legal duration), the client records will be destroyed in a manner that preserves your confidentiality.

HIPPA Acknowledgement of Receipt

By initialing this page, and signing at the end of this document, you agree that you have received the Notice of Privacy Practices and that Tiana Beard, LMFT can use and disclose your protected health information in accordance with HIPPA. This Notice of Privacy Practices, among other points, explains how I plan to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. This applies to the privacy practices of mental health treatment and information provided by Tiana Beard, LMFT. You have the right to review the Notice of Privacy Practices prior to initially this page, and signing this document. It provides more detail on how your information may be use and disclosed. The Notice of Privacy Practices is subject to change, at which point you will be updated on any changes that affect you and/or your treatment.

Your initials on each page, along with your signature at the end of this document indicate that you have reviewed, understand and agree the limits of confidentiality and the informed consent, acknowledging that you understand their meanings and ramifications.

Client's Name (print)	**Date of Birth**	**Client's Name (print)**	**Date of Birth**
Client's Name (print) **(For Couple's or Family Therapy Only)**	**Date of Birth**	**Client's Name (print)** **(For Family Therapy Only)**	**Date of Birth**
Client's Signature **(Client or Parent/Legal Guardian Signature if applicable)**	**Date**	**Client's Signature** **(Client or Parent/Legal Guardian Signature if applicable)**	**Date**
Client's Signature **(Client or Parent/Legal Guardian Signature if applicable)**	**Date**	**Client's Signature** **(Client or Parent/Legal Guardian Signature if applicable)**	**Date**

Therapist's Signature **Date**

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