Dr. Robyn El-Bardai, PsyD **Clinical Psychologist** **CA License PSY26738**
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INFORMED CONSENT FORM

This document provides important information regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

Information about Your Therapist

My name: Dr. Robyn El-Bardai, PsyD. I am a Licensed Psychologist; CA License Number: PSY26738

Information on my experience, education, special interests, and professional orientation can be found on my website. You are free to ask questions at any time for further details.

Fees and Insurance

The fee for service is $145 per individual therapy session. Payment is due at the beginning of each session. You will be provided a receipt of payment. You will be given adequate notice whenever fee increases are necessary.

If you believe you need to use our sliding fee scale, please discuss this with me at your introductory session. While I do not accept insurance at this time, please inform me if you wish to utilize health insurance to pay for services. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage and submitting insurance claims. I am unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with me at the start or during the therapy process.

You are ultimately responsible for all fees incurred. However, if for some reason you find that you are unable to continue paying for your therapy, you should inform me beforehand so that we can discuss any options that may be available to you at that time.

Payment: I agree to a payment of $_____ per session. Payment is due at the beginning of each session.

Please note that you are legally responsible for payment in all cases regardless of your arrangement with your insurance company, even when your insurance company does not reimburse you.

Missed Appointments: In order to cancel or reschedule an appointment, you are expected to notify me **at least 48 hours in advance** of your appointment. If you do not provide me with at least 48 hours' notice, you will be responsible for payment for the missed session.

CLIENT'S NAME: _____

SIGNATURE: _____ **DATE**: _____

Confidentiality

All communications between us will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, I will not disclose information communicated privately to me by one family member, to any other family member without written permission.)

There are exceptions to confidentiality. For example, therapists are required to report instances of **suspected child or elder/dependent adult abuse**. Therapists may be required or permitted to break confidentiality when they have determined that **a client presents a serious danger of physical violence to another person, the property of others, is gravely disabled, or when a patient is dangerous to him or herself.** 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.

Minors and Confidentiality

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. To maintain a trusting relationship with your child, I will not reveal our conversations unless I deem it imperative. In the exercise of my professional judgment, I may discuss the treatment progress of a minor patient with the parent or caretaker at that time. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic before the instigation of therapy or as the circumstances change.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify me at least 48 hours in advance of your appointment. If you do not provide me with at least 48 hours' notice, you will be responsible for payment for the missed session.

In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Be aware of the following resources that are available to assist individuals who are in crisis:

Alameda County Crisis Hotline: 1-800-309-2131 Contra Costa Crisis and Suicide: 800-833-2900

Nationwide Hotline: 1-800-SUICIDE 1-800-273-TALK (8255)

National Domestic Violence Hotline 1-800-799-7233 | 1-800-787-3224 (TTY)

Also try the **ACCESS Program 1-800-491-9099.** *ACCESS stands for Acute Crisis Care and Evaluation for System-wide Services - for Alameda County Residents*.

Therapist Availability/Emergencies

You may leave me a message at any time on my confidential voicemail (**510.435.7444**) if you have a matter of deep concern. If you wish me to return your call, please be sure to leave your name and phone number (repeated), along with a brief message concerning the nature of your call. I will attempt to keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions. You should be aware that I am generally available to return phone calls within approximately 24 hours.

Therapist Communications

I may need to communicate with you by telephone, email, or other means. Please indicate your preference by checking one of the choices listed below. **Please be sure to inform me if you do not wish to be contacted at a particular time or place, or by a particular means.**

Please write yes or no in the spaces:

____ My therapist may call me at my home. My home phone number is: ( ) _____
____ My therapist may leave a message on my home answering machine.
____ My therapist may call me on my cell phone. My cell phone number is: ( ) _____
____ My therapist may leave a message on my cell phone.
____ If someone other than me answers the phone, my therapist may ask for me by name. My therapist will not identify herself as my therapist without my permission except in an emergency.
____ My therapist may send mail to me at my home address.
____ My therapist may communicate with me by email. My email address is: _____

____My therapist may send a fax to me. My fax number is: ( ) _____

Please be sure you consider the security and confidentiality issues whenever you use electronic means of communication. Also, consider who is likely to access your telephone answering machine and mail.

About the Therapy Process

It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. During therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings, but this will be in the service of healing. I believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I will also periodically provide feedback to you regarding your progress and invite you to give me feedback about the service you are receiving. Treatment is collaborative. Due to the varying nature and severity of problems and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

Professional Records

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If either of us determines that you are not benefiting from treatment, we may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy. 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 that you have about this information before you sign and during the course of therapy as the need arises.

Name of Patient _____ Signature: _____ Date: __/__/_

I also acknowledge receipt of a copy of HIPAA NOTICE OF PRIVACY PRACTICES

Signature: _____ Date: ____ _/_____/_____