Informed Consent and Disclosure Statements

Welcome to my practice. This document contains important information about my professional services and policies. Please read the entire document carefully and ask any questions you have regarding its contents.

Information About Me

Prior to beginning treatment, I will discuss my professional background and provide you with information regarding my experience, education, special interests, and professional orientation. I am a Licensed Marriage and Family therapist.

About the Therapy Process

It is my intention to provide services that will assist you in reaching your goals. We are partners in the therapeutic process. As partners, we will work together to develop a plan for your treatment. Based on the information you provide to me and the specifics of your situation, I will offer feedback and recommendations regarding your treatment and progress.

Over the course of therapy, I will attempt to evaluate whether the therapy provided is beneficial to you. While I hope our work together will be effective, the amount and length of treatment varies from patient to patient. I am unable to predict how long you will be in therapy or guarantee a specific outcome or result of our work together.

Therapy sessions are approximately one hour each. Typically, sessions are scheduled once per week, at the same day and time each week. Consistent attendance contributes greatly to a successful outcome.

Fees and Insurance

The fee for service is $ 125.00 per individual therapy session.
The fee for service is $ 150.00 per conjoint (marital /family).
The fee for service is $ N/A per group therapy session.

Fees are payable at the time services are rendered. I accept payment in the form of personal checks or bank checks. My goal is to maximize your session time. You are ultimately responsible for payment for services received, even if you are relying on, or expecting, your insurance company or another third-party payor to cover the costs of treatment. I will notify you in the event of any changes to fees or when other charges

are to be applied. If you are experiencing financial difficulty, please let me know so we can discuss your care options.

Please inform me if you wish to use health insurance to pay for your services. I do not accept insurance. I am a private pay/cash pay business only. However, I am happy to provide you with a superbill (a.k.a. a receipt for services) which you can submit to your insurance for potential reimbursement. Depending on the terms of your health coverage, your plan may or may not reimburse for out-of-network services.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur once per week on the same day at the same time, if possible. I may suggest a different amount or frequency of therapy depending on the nature and severity of your concerns. Your consistent attendance can greatly contribute to a successful therapy outcome. To cancel or reschedule an appointment, please notify me at least 24 hours in advance of your appointment. If you do not provide me with at least 24 hours' notice of cancellation, you will be charged the full fee for the missed session. If you are using insurance, please be aware that your insurance company will not pay for missed or cancelled sessions. Accordingly, you will be responsible for covering the cost of missed sessions and sessions cancelled.
Your Right to Confidentiality- As a psychotherapy patient, you have a right to confidentiality with respect to information related to our work together. Accordingly, information shared between us will generally remain confidential.

Exceptions to Confidentiality

In certain, limited instances, the law requires me to disclose information pertaining to my work with you. For example, as a therapist, I am required to report suspected child, elder, and dependent adult abuse. Please note that the legal definition of "child abuse" generally includes instances of "sexting" in which a person *of any age* captures, records, sends, receives, or possesses an image or video depicting a minor engaged in sexual or otherwise obscene conduct.

Similarly, if I believe you present a serious and imminent danger to yourself, another person, or the public, I may be required to disclose information to emergency medical services, law enforcement, and/or another third party that can help to reduce or prevent that danger.

Confidentiality and Treatment of Minors

If a minor's parent(s) or guardian(s) give consent for me to treat the minor, I typically provide the parent(s) or guardian(s) with general updates about the minor's treatment. These updates may include the minor's diagnosis, treatment plan, progress in therapy, session attendance, or similar information. However, I generally do not share specific details about the minor's treatment or what the minor has shared with me during sessions unless: 1) the minor gives me permission to disclose such information and I

believe the disclosure would be clinically appropriate; or 2) the minor is experiencing a crisis or other emergency circumstance that would authorize me to break confidentiality.

If the minor consents to their own treatment, the law generally prohibits me from communicating with their parent(s) or guardian(s) without written authorization from the minor unless the minor is experiencing a crisis or other emergency circumstance that would authorize me to break confidentiality.

Please feel free to reach out to me if you have questions about these policies or if you would like to discuss them further.

Confidentiality and Couples / Family Therapy

If you are participating in couples or family therapy, please be aware that, in most circumstances, the law prohibits me from disclosing confidential information and records regarding the unit of treatment's services unless ***all*** identified patients provide written authorization to release the information.

No Secrets Policy

I would also like for my couples and family therapy patients to be aware that I utilize a "no-secrets" policy. This means, when I determine it is clinically appropriate or necessary to do so, I am able to disclose information I obtain from one member of the couple, or a participating member of the family therapy unit, (i.e. the "treatment unit") with the other member(s) of the treatment unit. This policy also applies to information a member of the treatment unit shares with me outside of couples / family sessions (e.g., via email, text, etc.) and information I obtain during individual session(s) with a member of the treatment unit (should we agree to hold individual sessions in furtherance of your couples / treatment goals). I find that this policy facilitates effective communication with and between my couples and family therapy patients. It also helps me to avoid potential problems which may arise when a therapist is perceived to be "keeping secrets" from other members of the treatment unit.

My Communication with You

From time to time, I may need to communicate with you outside of our sessions to discuss scheduling, payment, or other issues related to your treatment. To respect your privacy, it is important for me to understand your communication preferences. Please indicate your openness to receive communication from me via the following methods:

Phone

My Home Phone Number is. ___________________________

- I authorize my therapist to call me at this number.
- I authorize my therapist to leave messages for me at this number.

My Cell Phone Number is. _____________________________

- I authorize my therapist to call me at this number.

- I authorize my therapist to leave messages for me at this number.

Additional Information About Unencrypted Text Messaging:

I value your privacy and take appropriate steps to preserve the confidentiality of information shared between us. However, it is important to be aware that certain risks may still be present when communicating via unencrypted text, such as technological failures or unintended access by third parties.

- I understand the information above and authorize my therapist to communicate with me via unencrypted text using the cell phone number I provided.

Email

My Email Address is. ______________________________

Additional Information About Unencrypted Email: I value your privacy and take appropriate steps to preserve the confidentiality of information shared between us. However, it is important to be aware that certain risks may still be present when communicating via unencrypted email, such as technological failures or unintended access by third parties.

- I understand the information above and authorize my therapist to communicate with me via unencrypted email at the email address I provided.

Mail

My Home Address is ______________________________

- I authorize my therapist to send necessary treatment-related information to me at this address.

Additional Communication Information and Preferences

Please feel free to inform me if there are additional communication preferences you would like for me to be aware of, or if you do not wish to be contacted at a particular time, place, or by a particular means.

I will do my best to honor your communication preferences, but please be aware that in certain instances, such as emergency circumstances, I may need to reach you through other methods.

Emergency Contacts

It is critical for me to know who I can contact if you are experiencing a medical or psychiatric crisis or other emergency circumstance. Please identify these individuals in the space provided below:

Emergency Contact 1

Name ________________________________

Emergency Contact 2

Name ________________________________

Relationship to Patient ____________________ Relationship to Patient ____________________

Home Phone Number ____________________ Home Phone Number ____________________

Cell Phone Number ____________________

Emergency Contact 3

Name ________________________________

Cell Phone Number ____________________

Relationship to Patient ____________________

Home Phone Number ____________________ Cell Phone Number ________

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Your Communication with Me

My Contact Information

Outside of our sessions together, my preferred methods of communication are as follows: Phone or text.
714-418-7454 and clients may use this number to call me, text me, or both. My email address: icahmurraykaufman@gmail.com

Nonurgent Communications

If you would like to contact me in-between sessions to discuss a nonurgent issue, such as scheduling or payment, please do so during my normal business hours of Monday-Friday, 10a.m.-7p.m.

Please understand that I may be in session with other patients or addressing other matters when you attempt to reach me. If you send or leave me a message, I will respond as soon as I am available, but please be aware that I may respond to your communication up to 24 hours after receiving your message.

Urgent / Emergency Communications

If you ever experience a medical or psychiatric emergency or if you are facing an emergency involving a threat to your safety or the safety of someone else, please call 911 to request emergency assistance. For your information,
other phone numbers for Orange County are:

Suicide Prevention Hotline: 1-800-273-8255 (24 hr. *Youth Shelter: (949) 551-8214*

Domestic Violence Help: 1-877-854-3594 (24 hr.) *Hospital: Hoag Hospital: 949-764-4624*

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on your clinical needs, the specifics of your treatment plan, and the progress you make towards achieving your treatment goals. While I hope you will find our time together beneficial and meaningful, I cannot guarantee the specific outcome(s) or result(s) your treatment will yield.
You may discontinue therapy at any time. If one of us determines you are not benefiting from treatment, we can discuss treatment alternatives. These alternatives may include, among other possibilities, changes to your treatment plan, referrals to other therapists, and/or termination of treatment.

Questions About My Policies

Please let me know if you have any questions about my policies or if you would like to discuss them further.

Informed Consent

Your signature below indicates that you have read this agreement for services and disclosures carefully, understand its contents, and consent to receive treatment from me.

Name

Patient’s Name (If You Are Not the Patient)

Relationship to Patient (If Applicable)

Signature

Date