Irvine Counseling and Hypnosis

Informed Consent

Please read this document carefully, fill out and sign..

Information About Your Therapist

My current license: Marriage and Family Therapist (# MFT 31444)

My certification: National Board-Certified Fellow in Clinical Hypnotherapy.

Information About This Practice

The name of this practice is: Irvine Counseling and Hypnosis

The individual who operates this practice is: Murray S. Kaufman, LMFT, NBCFCH

Fees and Insurance

The fee for service is $ 125.00 per individual session.

The fee for service is $ 125.00 per conjoint (marital/family) therapy session.

Individual Sessions and conjoint (marital/family) therapy sessions are 90 minutes-for the initial session, with no added charge for the added 30 minutes.

Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies and alternate payment procedure.

Please inform your therapist if you wish to utilize insurance to pay for services. Your therapist is an out of network provider, and will provide you with a receipt for your paid services. This receipt can be sent with a claim to your insurance company who may reimburse you for an amount based on your policy and coverages. We are unable to guarantee whether your insurance company will provide reimbursement for the services provided to you. To learn more, please contact your insurance company directly.

If for some reason you find that you are unable to continue paying for services, please inform this therapist, and this therapist will be willing to consider any options that may be available to you at that time.

Confidentiality

All communication between you and your therapist 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, your therapist 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. However, it is important that you know that this therapist utilizes a “no-secrets policy when conducting family or marital/couples therapy. This means that prior to conducting an individual session, you will be informed of this policy, so that you can share the information with the other participant(s), or do so in the next family, or marital/couples therapy session.

Please feel free to ask this therapist about his “no secrets” policy and how it may apply to you.

There are four (4) exceptions to confidentiality as follows:

a. If a client presents as a serious danger of physical violence to another person.
b. If a client presents as a serious danger to him or herself.
c. If there is suspected child abuse.
d. If there is suspected dependent adult abuse.
e. In each of these exceptions, *if certain criteria are met*, this therapist is mandated by law to file a report with the authorities.

Minors and Confidentiality

Communications between this therapist and clients who are minors (under the age of of 18) are confidential. This therapist, however, can let parents know whether of not their child is or is not making progress.

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

You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis:

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

Therapist Communications

This therapist may need to communicate with you by telephone or other means. Please indicate your preference by filling out the information requested:

My therapist may call me on my home phone. My home phone number _____.

My therapist may call my cell phone. My cell phone number is _____.

My therapist may send a text message to my cell phone. (See above)

My therapist may call me at work. My work phone number is_____

My therapist may communicate with me by email. Email address is _____

My therapist may send mail to me at my home address_____

My therapist may send mail to me at my work address_____

Sensitive clinical information is to be discussed over the phone, online video or in person. For appropriate email or text communication, this therapist will respond to you within 24 hours. Potential risks of using electronic communication may include, but not limited to; inadvertent sending of an email or text containing confidential information to the wrong recipient, theft or loss of the computer, laptop or mobile device storing confidential information, and interception by an unauthorized third party through an unsecured network. Email messages may contain viruses, or other defects and it is your responsibility to ensure that it is virus-free. In addition, email or text communication may become part of the clinical record.

About the Clinical Process

It is this therapist's intention to provide services that will assist you in reaching your goals. Based upon the information you provide this therapist and the specifics of your situation; your therapist will provide recommendations to you regarding your treatment. We believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with this therapist's recommendations. This therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the process.

This therapist will work with you to develop an effective treatment plan. Over the course of therapy, this therapist will evaluate with you whether you feel that the therapy has been beneficial to you. Your feedback and input are an important part of this process. This therapist will assist you in effectively addressing the problems and concerns you are experiencing. However, due to the individuality of each client, this therapist will not be able to predict the length of time that the therapy will take. This therapist will ask you at every 5 therapy sessions for your evaluation of the therapy, as well as provide you with how this therapist sees your progress, and this therapist welcomes your questions at any time.

Finishing the Therapy

This therapist suggests that prior to making a decision to leave therapy, that you consider having one more appointment, in order to have closure. This means that you and the therapist have an opportunity to talk about the progress made, and your next steps, so this therapist can make suggestions as to how to care for yourself after the therapy is completed.

You may discontinue therapy at any time. If you or this therapist determines that you are not benefitting from treatment either of you may initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or finishing your therapy.

Your signature indicates that you have read this agreement for services carefully and understand its contents.

Please ask this therapist to address any questions or concerns that you have about this information before you sign.

NOTICE TO CLIENTS

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of ***licensed marriage and family therapists*** You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

_____

Name of Client

_____

Signature

_____

Date