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APPLICATION FOR SERVICES AND CONSENT TO TREATMENT

Welcome to my practice. This document contains important information about my professional services and business policies and how they may affect you. Please read carefully and make note of any questions you want to discuss with me. Once you sign this document it will become a binding agreement between us and also provide your consent for us to begin therapy.

Therapy is a unique and highly individual experience with the outcome determined by the effort and motivation you bring to work towards a change in yourself and how you see the world around you. It can result in a number of benefits to you and can potentially help in your ability to detect, challenges and change beliefs and attitudes that create, maintain, and worsen feelings of depression, anxiety, panic, anger, frustration, etc. Therapy also has the potential to help you gain new or deeper understanding about your issues and learn new ways of coping with and solving them.

However, there is no guarantee that therapy will yield positive or intended results. Because feelings will be explored, you may feel a range of emotions that can be intense and uncomfortable at times. During the course of therapy some of you assumptions, perceptions, or behaviors may be challenged, which can cause you to feel upset, angry, depressed, uncomfortable, confused, or disappointed. I encourage you to explore those feelings during our sessions, as they are part of the therapeutic process. In the attempt to resolve issues that originally brought you to therapy, unintended changes in your personal and interpersonal relationships my result.

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 appropriate referrals and assist you in the transition to a new therapist.

Sessions

Each session is 50 minutes and will begin at the time agreed. If you arrive late to the appointment, I will end the session at the allotted time.

Cancellation and Rescheduling

If you need to cancel or reschedule a session, please notify me by telephone or email at least 24 hours in advance of our scheduled session.

Contacting me

You may contact me at 415-235-5747 Monday through Sunday until 8pm. I will try my best to reach you within 24hours of your phone call. I will only return calls in the cases of emergency. Phone calls are generally limited to 10 minutes beyond this time you will be charged at a prorated amount of my usual fee.

Email Usage

Therapy is confidential. You can be confidence that your insights, vulnerable experiences, and feelings will not be repeated outside the therapeutic relationship establish.

Email correspondence is NOT confidential. Though internet security measure can be effective, it is never 100%.

My policy regarding email usage is as follows.

- Email correspondence with me is NOT secure
- Email correspondence is NOT a substitute for person-to-person therapeutic treatment, unless discussed with me in advance and in person.
- Email correspondence will not play a part in your therapy.
- I will not respond to your emails in general. Anything stated in an email from you will be discussed in session, and in session only.
- Email correspondence is NOT to be used in the case of an emergency to contact me.
- If you need to contact me with something that demands immediate attention, you will do so voicemail at the following number 415-235-5747, call 911 or go to the emergency room.
- If it becomes necessary, I will terminate treatment if email usage is or become inappropriate.

CELL PHONE USAGE AGREEMENT

I am sharing my work cell phone number with you to be able to communicate with you. My work cell phone is only available during my work hours and is turned off when I am not at work. If you leave a voicemail or text I will respond within the next 24 hours. You may call my cell phone to ask for the address of a planned appointment, or to confirm or cancel your appointment. To respect each client, I will not answer my phone when I'm with another client. Please leave a message. I will keep my office voicemail and cell phone greetings updated with my work schedule and time away. These greetings will include information on how you can receive urgent assistance if I am not available. Text messages are for logistics only, such as appointment confirmation. Your privacy is very important to me and since text messages do not meet privacy standards, they should not include private health information. You may text me if you have an urgent need, but please reserve clinical details for a voicemail or a voice to voice conversation. Important numbers:

- o My cell phone number 415-235-5747
- o 24/7 Suicide Crisis Hotlines 1 (800) 273-TALK (8255) or (650) 579-0350; For Spanish: 1 (888) 628-9454
- o Crisis Text Line serves anyone, in any type of crisis, providing access to free, 24/7 support. Text BAY to 741741 to reach a crisis counselor.

Emergencies

If you are experiencing a life-threatening emergency and need to talk to someone immediately call 911, the Suicide Prevention Hotline at (800) 273- TALK (8255), the police or your local emergency room and ask for the psychologist or psychiatrist on call.

Confidentiality

Everything you say and share in session is strictly confidential. However, there are some exceptions to the rule of confidentiality.

I am required by law to report:

- Threats of harm to another or oneself
- Suspected child or elder abuse (past or present)
- By court order

Other exceptions include:

- Per your signed release
- I may discuss your case with peers in order to provide excellent services. In doing so, I will keep your identity or any details allowing your identification confidential.

With minors, confidentiality will be kept unless there is concern that the child is in danger to themselves, someone else, or has been harmed. In these cases the parent(s) will be notified of the concern and if possibly, I will have discussed the matter with the minor and have done my best to handle any objections he/she may have. During treatment, I will provide parents with only general information about the progress of treatment and the attendance of scheduled sessions.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (ROI)

To provide you the best care possible, I will share information and communicate with your other health care providers.

We would also like your permission to talk with important support people in your life, such as family members, social

workers, probation officers, social services, and other agencies involved in your treatment.

Who are people that we should share information with to improve your care?

Are you okay with me talking with and sharing your information with?

I will only share the minimal amount of information needed related to your care. Do you have any limitations that you would like to talk with me about?

Unless consent is revoked, this authorization shall be in place until the date we pick to end the consent (may be 1 to 10 years) or upon discharge from my Services, Behavioral Health and Recovery Services, whichever occurs first.

TELEHEALTH INFORMED CONSENT FORM (required for all clients participating in telehealth)

I may be providing you services at times using videoconferencing equipment. When we do this, you will be able to see and hear me and I will be able to see and hear you, just as if we were in the same room.

Are you okay with participating in services by video and/or phone when it is appropriate? Telehealth can improve your access to care by allowing you to be at a different location than me.

You are not required to participate in video if you are uncomfortable and may schedule a telephone session instead. Safety measures are being used to ensure that videoconferencing is secure, and no part of the encounter will be recorded without your consent. You have the right to withdraw consent to the use of telehealth in the course of my care at any time, without affecting your right to future care or treatment. The laws that protect your privacy and confidentiality of medical information also apply to telehealth.

Fee and Payment

Your session fee will be agreed upon by therapist and client. Payment of this fee needs to be made at the beginning of each session in full unless other arrangements have been made. Your session fee may be increased annually. In the event of any fee changes, you will be notified at least 30 days prior to such change.

Additional Fees

Extended sessions and telephone conversations that exceed ten minutes will be charged a fee based on your regular session fee. Written reports, evaluations authorization or requested by you or copying your file follow the same policy.

Agreement

I have read this information fully and completely, I have discussed any questions I had about the information, and I understand the information. I acknowledge that it is my choice to participate in my psychotherapy (or have my child participate). I realize that the outcome of therapy depends upon my personal investment in the therapy process. I have familiarized myself with the fees for charges provided by Gloria M. Paz LMFT, and I understand and agree that the therapeutic services rendered will be charged to me and not to any third-party payer. I acknowledge responsibility for payment of these services.

Please fill out the next form to complete Your E-Signature:

Gloria M. Paz.com

Gloria M. Paz Informed Consent