# PSYCHOTHERAPY INFORMED CONSENT

I, _____ by my initials at the bottom of each section, and my signature at the end of this document, attest that I have totally read and fully understand the following document.

I understand that psychotherapy is a complex blend of both interpersonal and professional dynamics. It is important that the ethical and business aspects be clearly understood, and agreed upon in order for them not to interfere with the therapeutic process. The following policies and procedures will allow optimal facilitation of our work together. Please know that you are welcome to make a copy for your own records.

## BENEFITS & POSSIBLE RISKS OF THERAPY

Therapy will seek to meet the goals established by all persons involved, when more than one person is involved. A better ability to cope, to handle and thrive with personal, couple, family and other interpersonal relationships is often one of the many gifts of therapy. Benefits relating to the processing and resolution of emotional and mental traumas, difficulties, concern or conflicts are often experienced during and after therapy sessions. Therapy may deal with sensitive, difficult and topics that are taboo, and may elicit uncomfortable emotions and thought processes, and may lead to decisions that are disruptive to oneself, couple and family. While the focus of therapy is to maximize its benefits, there is no guarantee that this will occur. The required duration of treatment is established as treatment goals are reached and embodied.

## APPOINTMENTS

1. **Time of Arrival to Sessions**: Currently, all sessions are online teletherapy via Doxy (HIPPA compliant platform). **Please log in to the link at the time of your appointment.**

**Initials: _____**

2. **Scheduling of Appointments:** As much as possible, we will do our best to create regularity and constancy of treatments. This will maximize your therapeutic gains. In the beginning of treatments frequency of appointments often range from once to twice a week (especially in periods of crisis), to a maximum of every ten days, two weeks and once a month in between sessions. We'll figure out the best sequencing of sessions in the early phase of our work together.

**Initials: _____**

3. **Cancellation Policies:** If you are unable to keep a scheduled appointment, a **24-hour notice of cancellation is required and must be done via email at maayaota.lmft@gmail.com and/or text/call at 323-304-1790**. These procedures are designed to preserve our therapeutic relationship intact, and avoid the possibility of misunderstandings and confusion. **Should the unfortunate situation of a "no show" or of a cancellation made less than twenty-four (24) hours prior to session occurs, the full fee of the scheduled session will be due**.

**Initials: _____**

**Session Length:** Unless otherwise arranged, psychotherapy sessions are 50 minutes long, as agreed upon at the beginning of treatment. Sessions longer than 50 minutes are charged for the additional time, pro rata. Your session begins and ends on time. Please arrive on time, it is your time. Please bring up important issues early in the hour, rather than waiting until the last minutes of your sessions. Doing so will help us both make the most of your therapy sessions.

4. **Additional Sessions:** If you feel you need additional sessions beyond your regular appointment, please ask. I will make every effort to schedule extra time for you.

**Initials: _____**

5. **Termination of Treatment:** You have the right to terminate treatment at any time. If you wish to terminate because you are dissatisfied with my services or have questions about my treatment methods and style, I invite

you to discuss your concerns with me as soon as possible so that we can, when possible, honor your needs. If you decide to stop treatment with me while you still want to be in treatment, if you so wish, I will provide you the names and telephone numbers of other possible therapists in order to ensure a smooth transition of your care. Therapists also have the right to terminate therapy under certain circumstances – for example, if a client is not benefiting from treatment after a reasonable length of time, or if a client could benefit more from receiving treatment elsewhere. Endings are as important as beginnings. Near the close of our work together, we will set aside time to reflect on the work that has been done, and the skills that have been gained, and how to use them when future needs might arise. Should you decide to return in the future, please know that I have an open door policy.

**Initials: _____**

**TELEPHONE & EMAIL CONTACT**

1. **Messages:** Occasionally, you might need to communicate with me between sessions. You may leave me messages on my confidential voicemail, or email me. I will return your call/email as soon as I can. **I am not able to be available for you 24 hours a day. If your safety is involved, please call 911 or go to the nearest emergency hospital.** Please call or email me afterwards, once your safety has been attended to. Please keep in mind that I do not address therapeutic material via email. Email communications are for practical matters, not therapeutic matters. Phone, Facetime, Skype and Zoom sessions are possible, especially in times of emergency, crisis, or travels, and shall be scheduled and considered as therapy time.

**Initials: _____**

2. **Fees:** Payment is due in full at each session. There is no fee for a brief (less than 8 minutes) phone conversation. If a pressing consultation is needed, and that we are unable to schedule an appointment because of the urgency of the moment, then a phone, Facetime, Skype or Zoom session can be scheduled; and will be charged at your regular therapy fee.

**Initials: _____**

**LEGAL & ETHICAL GUIDELINES**

1. **Confidentiality:** The information disclosed by you is confidential and will not be released to a third party without written consent from you, except where required, or permitted by law. **Exceptions to confidentiality include**: the exchange of information necessary for **insurance billing**; **certain court matters**; **potential danger to self or others**; **suspicion of child, elder, or dependent adult abuse**. In a situation where a client is a danger to self or others, I may be required to take protective measures. Those may include: notifying a potential victim, notifying family members or others who may provide protection, contacting the police, hospitalizing my client, etc. As much as possible, I will make every reasonable effort to avoid having to implement any actions that would breach confidentiality.

**In order to preserve the confidentiality of a client who is in therapy, it is my ethical policy to never acknowledge a client if/when/should I run into him or her in the outside world**. This prevents the possibility of a third party asking my client how he or she knows me, or any other situations that could make my client uncomfortable, or risk the confidentiality of the therapeutic relationship to be jeopardized. Should a client decide to say hello, I'll be glad to return the greeting and will keep the encounter cordial and brief. In the same spirit, the BBS (Board of Behavioral Sciences), encourages us to decline offers to join social networks such as Facebook, LinkedIn, and others. My goal, again, is to do all I can to preserve the boundaries of the therapeutic relationship.

**Initials: _____**

2. **Confidentiality in Couple and Family Counseling:** Confidentiality is held by the unit of the couple, or the family; not by a specific individual. In situations where one person, or a legal entity, requests that I release information about anyone in a unit of treatment, I don't unless all people involved each sign an authorization. Exceptions to this are as stated above, or if required, or permitted by law. **I will not collude, or be triangulated, with individual members of a couple, or a family, to keep confidences or secrets which can't be shared with the other person(s) of the unit of treatment. The risks that such confidences**

**be harmful or destructive to the unit of treatment are too great to even consider keeping secrets a viable option.** Where conflicting couple's and family members' goals exist, the objective of therapy is for everyone's goals to be addressed in a manner that preserves the integrity of the couple or family as a whole.

**Initials: _____**

3. **Consulting with other Professionals**: On occasion, it may be necessary for me to consult with other professionals so that I can offer the best care to my clients. During such professional consultations, every effort is made to protect the identity of my client(s). Should the professional colleagues(s) I consult with know my client(s), consultation will not take place. **Professionals I consult with are full-fledged licensed or pre-licensed therapists whom, like myself, are legally mandated to keep all information gathered during such consultation(s) strictly and totally confidential.**

**Initials: _____**

4. **Substance Use and Abuse:** The use and abuse of substances such alcohol, marijuana, or any other legal or illegal substances that impair judgment, increases or diminishes emotional awareness or experience is contrary to productive work in psychotherapy. If you come to session while under the influence of such substances, the session will be terminated and you will be billed for the time.

**Initials: _____**

**TREATMENT OF MINORS or DEPENDENT ADULTS (Skip If Doesn't Apply)**

Your signature on this section indicates that you are the legal guardian, or legal representative of the minor, or of the dependent adult named below, and that you can legally authorize mental health treatment on behalf of the minor or dependent adult with Maaya Ota, M.A., LMFT (MFC 52809). Your signature in this section stipulates that you understand that all of the

policies and procedures described in this document, apply to the minor, or dependent adult, whom you represent.

_____ Name of Minor/Dependent Adult (Print)

_____ Parent/Guardian/Legal Representative

_____

Maaya Ota, LMFT, (MFC 52809) Date

**CONSENT FOR TREATMENT**

I understand and accept all of the guidelines and policies contained in this agreement.

_____ Client's Name (Print)

_____ Client's Signature

_____ Date

_____

Maaya Ota, LMFT, (MFC 52809) Date