Cal J. Domingue, LMFT
Licensed Marriage & Family Therapist
MFC39338

3896 24th St
San Francisco, CA 94114
(415) 377-0544

Informed Consent

I, _____, hereby consent to psychotherapy treatment with Cal J. Domingue, MFT (license MFC39338). I understand that psychotherapy includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, exchange of medical data, and education using interpersonal, interactive audio, video, or data communications.

I understand that I have the following rights with respect to psychotherapy:

(1) I have the right to withhold or withdraw **consent** at any time without affecting my right to future care or treatment, nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the **confidentiality** of my medical information apply to psychotherapy. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable information from the psychotherapeutic interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are **potential risks and benefits** associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may worsen.

(4) I understand that I may benefit from psychotherapy, but that **results cannot be guaranteed or assured**. The benefits of psychotherapy may include, but are not limited to: a greater ability to express thoughts and emotions, improvement in interpersonal relationships, and increased self-awareness.

(5) I understand that I have a right to **access my medical information** and copies of medical records in accordance with California law.

I understand that I have the following **responsibilities** with respect to psychotherapy:

1) Psychotherapy may also involve the **communication of my medical/mental health information**, both orally and visually, to health care practitioners. I agree to inform my psychotherapist of my other health care providers, and to sign consent forms allowing communication between them, relevant to my treatment and care.

2) Fees

a) Fees have been disclosed to me. I agree to the fee of **$180 per 50-minute session**. Fees for longer sessions are pro-rated based on this rate.
b) I agree to be responsible for half of the regular fee for any attempted tele-therapy sessions that are abandoned because of unresolvable technological difficulties.
c) I understand reasonable notice will be given before any change of fees.
d) If I request a service which requires more than 10 minutes of the therapist's time outside of session (e.g. reading & replying to emails, research, responding to legal requests, etc) I agree to pay for that time: 1-at the therapist's current fee rate for time in sessions on the date the request is made; 2- pro-rated for the amount of time spent meeting the request.
e) I agree to pay for services when delivered, and that if I am in default on payment for services, this may lead to termination of services by the psychotherapist and/or collection of these fees by a collection agency.

3) I understand there is a **48-hour cancellation notice** requirement. I agree to pay for any planned session I do not attend, if I have not given at least 48 hours' notice of my intent to miss the session. I understand that this does not apply to emergency situations, in which cases I agree to give as much notice as possible.

4) I agree to provide a **credit card to be kept on file**, and that this card will be charged for any missed or unpaid sessions unless other arrangements are made. My card number is: _____ ; expiration is _____; security code is _____; zip code is _____.

I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

_____ _____
Signature of patient/parent/guardian/conservator Date
(If signed by other than patient indicate relationship)

_____ _____
Signature of psychotherapist Date