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AGREEMENT FOR TREATMENT / INFORMED CONSENT

Introduction: This Agreement is intended to provide [first & last name(s)] 1st client _____, 2nd client if a couple _____ (herein "Client(s)") with important information regarding the practices, policies and procedures of Michelle Gross (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Client. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Risks and Benefits of Therapy: Psychotherapy is a process in which Therapist and Client discuss a myriad of issues, events, experiences, and memories for the purpose of creating positive change so Client can experience his/her life more fully. It provides an opportunity to understand oneself better, and more deeply, as well as any problems or difficulties Client may be experiencing. Psychotherapy is a joint effort between Client and Therapist. Progress and success may vary depending upon the problems or issues being addressed, as well as many other factors.

Participating in therapy may result in several benefits to Client, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of Client, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts, and behaviors. There is no guarantee that therapy will yield any or all the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings, and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Client's perceptions and assumptions and offer different perspectives. The issues presented by Client may result in unintended outcomes, including changes in personal relationships. Client should be aware that any decision on the status of his/her personal relationships is the responsibility of Client.

During the therapeutic process, many Clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times but may also be slow and frustrating. Client should address any concerns he/she has regarding his/her progress in therapy with Therapist.

Professional Consultation: Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Client.

Court-related Services: Therapist is not a forensic therapist and reserves the right not to participate in legal proceedings, nor offer therapist's opinion to any court of law in the form of a letter, consultation, appearance, or telephone testimony for the court. If asked to do so, therapist will consider, on a case-by-case basis, whether therapist can adequately participate in court-related services. Therapist will not voluntarily participate in any litigation, or custody dispute in which Client and another individual, or entity, are parties. Therapist has a policy of not communicating with Client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Client's legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Client, Client agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made himself available for such an appearance at Therapist's usual and hourly and Record Keeping

Therapist may take notes during session and will also produce other notes and records regarding Client's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his normal record keeping process at the request of any Client. Should Client request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Client with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Therapist will maintain Client's records for ten years following termination of therapy. However, after ten years, Client's records will be destroyed in a manner that preserves Client's confidentiality.

Confidentiality: The information disclosed by Client is generally confidential and will not be released to any third party without written authorization from Client, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a client makes a serious threat of violence towards a reasonably identifiable victim, or when a client is dangerous to him/herself or the person or property of another. When more than one family member is being seen in therapy (i.e., in couple or family sessions) the therapist views the family as a whole as the client. Therefore, releases of information for family sessions require the written approval of each consenting member of the family who was present at any time during the treatment. (This does not apply to a 'guest' whom the client invites who is not the focus of treatment.) Additionally, the family must agree that the therapist will not collude with individual members to keep

individual confidences that are harmful or destructive to other family members in treatment. Where conflicting family members' goals exist, the objective of therapy is for everyone's goals to be addressed in a manner that will preserve the integrity of the family. Differences between each family member's goals will be discussed during therapy. Please initial here: _____/_____

Psychotherapist-Client Privilege: The information disclosed by Client, as well as any records created, is subject to the psychotherapist-Client privilege. The psychotherapist-Client privilege results from the special relationship between Therapist and Client in the eyes of the law. It is akin to the attorney-client privilege or the doctor-Client privilege. Typically, the Client is the holder of the psychotherapist-Client privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist would assert the psychotherapist-Client privilege on Client's behalf until instructed, in writing, to do otherwise by Client or Client's representative. Client should be aware that he/she might be

waiving the psychotherapist-Client privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Client should address any concerns he/she might have regarding the psychotherapist-Client privilege with his/her attorney.

Appointment: Your appointment time is weekly on _____ at _____. Sessions last 55- 60 minutes. This time will remain reserved for you until other arrangements are made, or therapy is terminated. This time will be held for you even if you did not attend treatment the previous week.

Fee and Fee Arrangements: The usual and customary fee for service is \$250 per 55-minute session. Sessions longer than 55 minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Clients will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payors, or by agreement with Therapist.

From time-to-time, Therapist may engage in telephone contact with Client for purposes other than scheduling sessions. The client is responsible for payment of the agreed fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at Client's request and with Client's advance written authorization. The client is responsible for payment of the agreed fee (on a pro rata basis) for any telephone calls longer than ten minutes. Clients are expected to pay for services at the time services are rendered. Therapist accepts Zelle, cash, and check. Unfortunately, credit cards are not accepted.

Insurance: Client is responsible for all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payor. The client is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles. Therapist is not a contracted provider with any insurance company, managed care organization. Should Client choose to use his/her insurance, Therapist will provide Client with a statement, which Client can submit to the third-party of his/her choice to seek reimbursement of fees already paid. In the event an insurance company or managed care organization seeks additional information to process a claim made by client, therapist reserves the right to refuse or limit the release of information requested by those third parties. On a case-by-case basis, therapist may respond to such requests at the therapist's discretion.

Cancellation Policy: Client is responsible for payment of the agreed upon fee for any missed session(s). The client is also responsible for payment of the agreed upon fee for any session(s) for which Client failed to give Therapist at least 24 hours' notice of cancellation. Cancellation notice should be left on Therapist's voice mail or via text at (805)824-4428.

Therapist Availability: Therapist's uses a confidential voice mail system that allows Client to leave a message at any time. The therapist will make every effort to return calls within 24 hours (or by the next business day) but cannot guarantee the calls will be returned immediately. This therapist is unable to provide 24-hour crisis service. If Client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

Termination of Therapy: The therapist reserves the right to terminate therapy at her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Client needs are outside of Therapist's scope of competence or practice, or Client is not making adequate progress in therapy. Client has the right to terminate therapy at his/her discretion. Upon either party's decision to

terminate therapy, Therapist will generally recommend that Client participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Client.

Acknowledgement: By signing below, Client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Client has discussed such terms and conditions with Therapist and has had any questions about its terms and conditions answered to Client's satisfaction. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Client agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____/_____/_____
Client Name (Please Print) Birthdate

_____/_____/_____
Client Name (Please Print) Birthdate

Street Address Street Address

Street Address Street Address

City, State Zip City, State Zip

City, State Zip City, State Zip

(____)_____
Best phone to reach you

(____)_____
Best phone to reach you

OK to leave therapy relevant VOICE messages? [Yes] [No]

OK to leave therapy relevant VOICE messages? [Yes] [No]

OK to text therapy relevant messages? [Yes] [No]

OK to text therapy relevant messages? [Yes] [No]

OK to discuss therapy via E-Mail? [Yes] [No]

OK to discuss therapy via E-Mail? [Yes] [No]

____@_____
Your Direct Private Email

____@_____
Your Direct Private Email

Signature of Client Date

Signature of Client Date

Emergency Contact: _____

Emergency Contact: _____

Best Phone: _____

Best Phone: _____

Relation to you: _____

Relation to you: _____