DEBBI MOLNAR, LMFT, LPCC

Licensed Marriage & Family Therapist (#MFC 49600)

INFORMED CONSENT

I am committed to providing you with the highest quality of care. Psychotherapy services are unique—both highly personal and at the same time a business contract. Because therapy often begins in a situation of considerable stress, a clear understanding and agreement about rights, responsibilities and limitations of the professional relationship are important. Please read the following information carefully.

Services Provided

I am a licensed Marriage and Family Therapist in the state of California. I have training in the practice of psychotherapy with adults, children, adolescents, couples and families. Additionally, I am a member of the California Association of Marriage and Family Therapists and am certified as Grief Recovery Specialist through The Grief Recovery Institute.

The Process of Psychotherapy

Psychotherapy varies depending on the therapist, the personality of the client and the particular problem being addressed. During the course of therapy, I will likely draw on various approaches according to the nature of the problem(s) being presented and a collaborative assessment of what might be beneficial.

Psychotherapy has both benefits and risks. Benefits may include reduced symptoms and resolution of specific problems that prompted psychotherapy. Therapy can also be uncomfortable. Change can sometimes be easy or rapid, but more often is gradual. Most people who receive treatment do benefit from therapy; however, there is no guarantee psychotherapy will yield positive or intended results. It is impossible to predict the outcome of treatment because success depends on many factors including your child's motivation, the parent's/guardian's motivation, the amount of effort put into change, and life circumstances.

Confidentiality

For therapy to be effective, confidentiality must be honored. Information shared with me by your child will be kept confidential. However, the goals and progress of therapy may be shared with a parent and any other legal custodial parent or guardian. I will be keeping in regular contact with you regarding your child's progress towards his/her goals. The information disclosed by the client (including that of a minor) will not be released to any third party without written authorization, except for professional consultation if needed and when required or permitted by law. Exceptions to confidentiality include but are not limited to:

- Suspected child abuse (sexual, physical or emotional) or neglect (a person under 18 years of age),
- Elder or dependent adult abuse (sexual, physical, emotional or financial) (a person 65 years or older),
- Threatening to harm oneself, others or property,
- When information is required by law or court ordered,
- If using insurance, information regarding treatment and diagnosis may be required.

Please note email, text and fax are not secure forms of communication and are not recommended as a means of contacting me for any treatment related concerns. I cannot guarantee the confidentiality of any communication sent to me via email, text or fax.

Appointments

Scheduling an appointment involves the reservation of a time specifically for you and/or your child. Once an appointment is scheduled, you are expected to keep it unless you provide a minimum of 24 hours prior notice and/or alternative arrangements have been mutually agreed upon. Full fee will be charged for any missed appointments or late cancellations. If you or your child is late for an appointment, I will not extend the appointment to make up for the lost time. If you have not called ahead, I will wait for no more than 25 minutes.

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Fees

MY fee for a 50 minute session (either in person or over the phone) is $_______________. Phone consultations are billed at the standard fee which will be prorated to the nearest quarter hour and will be added to your next session's bill.

Payment for all fees is due and payable at the time services are rendered, unless other payment arrangements have been approved in advance. I accept cash, checks, MasterCard and VISA. All checks should be made payable to Debbi Molnar. Psychotherapy expenses are your responsibility, regardless of your insurance coverage. In the case of minors, payment is the responsibility of the parent who consents to treatment.

If you wish to use health insurance, you will still pay me directly at the time of service and then you may obtain reimbursement from your carrier. I strongly recommend you clarify your mental health benefits with your carrier before incurring the cost of services. The responsibility for knowing and verifying your health insurance eligibility and benefits rests with you. Upon request, I can provide you with an itemized statement you can submit to your insurance company to obtain reimbursement. Regardless of your insurance status, you are ultimately responsible for full payment for all professional services rendered. Disclosure of medical information regarding conditions being treated and services being provided is generally required by insurance companies. You hereby authorize release of this information for this purpose only. While insurance companies generally assure clients that no information will be released to other third parties, once information leaves this office, I cannot guarantee its security. Regardless of coverage, insurance companies will not reimburse for missed appointments or late cancellations. You will be responsible for the cost of these sessions in full.

Children under the age of 14 cannot be left unattended in the waiting area.

Phone Calls and Emergencies

My phone is answered 24 hours a day by voicemail which is monitored regularly. I usually return calls within 24 hours, with the exception of weekends and holidays. I cannot guarantee a phone response within a certain period of time. If you are unable to reach me and have an emergency that cannot wait, call your family physician, or 911 or go to the nearest emergency room. When I am not available for an extended period of time, I will have a colleague available for you to contact.

Parental Consent

The goal of therapy is to help your child be successful emotionally, socially and academically. Individual, couple and family counseling is available to enhance your child's success. I am requesting your involvement and need your permission to see your child.

This consent is valid until termination of the therapeutic relationship. You have a right to revoke consent at any time. Verbal or written notification will be accepted.

Upon signing below, the parent(s) and/or legal guardians of the minor client acknowledges that s/he has read the informed consent and understands and agrees to the conditions stated above. I/We have clarified any questions before signing this consent. I/We consent for Debbi Molnar, LMFT, LPCC to render therapeutic services to myself/us and/or my/our minor child(ren).

Child Name ____

Parent/Guardian Name ____

Parent/Guardian Signature ______________________________ Date __________

Child Name ____

Parent/Guardian Name ____

Parent/Guardian Signature ______________________________ Date __________