Debbie G. Ramirez, LCSW

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Informed Consent for Services

I look forward to working with you and want to offer you some important information about the services that you will receive from me. This consent form will provide a clear framework for our work together and will begin to build our therapeutic relationship. Please feel free to discuss any concerns that arise.

In the following paragraphs I, Debbie G. Ramirez, LCSW, am referred to as “Therapist.”

Introduction: Debbie G. Ramirez is a Licensed Clinical Social Worker (LCSW) and has over 10 years of clinical experience working with adults, adolescents, and children. She completed her graduate studies in social work at USC. She has experience with a wide range of psychological issues and has served in leadership positions in behavioral health organizations throughout her career. Debbie Ramirez has trained and supervised psychologists and therapists for over 5. Throughout her career she has been involved in training and research. Her clinical specialties include anxiety, depression, trauma-related symptoms, grief and loss, and relationship issues.

Through our collaborative relationship much is possible. I look forward to facilitating your growth toward greater life fulfillment.

1. **Confidentiality**: As Client’s therapist, Therapist is legally prohibited from revealing to another person that Client is in therapy with Therapist, nor can Therapist reveal what Client has said to Therapist in any way that identifies Client without Client’s written permission. However in the following instances, Client’s right to confidentiality must be set aside as required by law or professional guidelines:

A. Instances of actual or suspected physical or sexual abuse, emotional cruelty, or neglect of a child or an elder or dependent adult must be reported to the appropriate protective services.

B. If Therapist has a reason to believe that a client poses an unavoidable and imminent danger of violence to another person, Therapist must warn the intended victim, and Therapist must also notify the proper authorities.

C. If you, as a client, reveal a serious intent to harm yourself, Therapist is ethically bound to do what Therapist can to help maintain your safety, which may involve notifying others who may be of assistance.

D. If a judge orders Therapist’s testimony or, in the context of a legal proceeding, you raise your own psychological state as an issue, Therapist might be required to release your confidential information to the court.

In all of the above cases, it is incumbent upon Therapist to release only that information necessary to appropriately carry out Therapist’s responsibilities. Client’s confidentiality still remains an ethical

priority. In order to provide the best possible service to Therapist's clients, Therapist may consult with other licensed professionals from time to time for additional therapeutic perspectives. In these consultations, Therapist will protect Client's anonymity. Unless Client objects, Therapist will not notify Client of these consultations unless Therapist feels that it is important to our work together.

I have reviewed, understand, and agree to the stated policies regarding confidentiality _________.
Initials

2. **Risks and Benefits of Therapy**: Psychotherapy is a process in which Therapist and Client discuss a variety 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 better, and more deeply understand one self, as well as, any problems or difficulties Client may be experiencing.

Participating in therapy may result in a number of 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 of 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 me.

I have reviewed, understand and agree to the stated policies regarding risks/benefits of therapy_______.
Initials

3. **Appointments**: Client's weekly appointment time is reserved for Client. Therapy sessions are normally a 50 minute hour. Clients under the age of 18 must be accompanied by a guardian, who must remain in the waiting area during the session. Cancellations must be made 24 hours in advance; otherwise, Client is responsible for the session fee. Cancellation notice should be left on Therapist's voice mail at (310) 704-6854. Therapist will make every effort to reschedule Client during the same week, but cannot guarantee that this will always be possible. Therapist is out of the office on weekends and holidays. Regular attendance is recommended to insure continuity of services and to enhance the effectiveness of the therapy.

Therapist will notify Client of intended vacation leave two weeks in advance. However, Therapist does reserve the right to cancel session without two weeks notice in cases of emergency. Therapist will provide as much advanced notice as possible.

I have reviewed, understand, and agree to the stated policies regarding appointments _________.
Initials

4. **Professional Fees and Payments**: Therapist's customary fee is $150.00__per individual psychotherapy session and ___$175.00___per couples or family session. Therapist and Client will discuss and establish our fee at the outset of treatment, and any fee change will be negotiated in good faith. Therapist's fees may increase over the course of treatment, but only with prior notification of three weeks and consideration of Client's financial ability to pay and to continue in treatment. Typically, fees will be raised once yearly. Payment is expected at the time of each session, unless we agree otherwise. Should Client wish to bill Client's insurance company for reimbursement, Therapist will provide Client with a billing statement for that purpose. Please be aware that a diagnosis is required by insurance companies for payment. Therapist will be happy to discuss this matter with Client should Client be interested.
Balances more than 120 days overdue may be subject to collection through the use of a collection agency. However, Therapist will first attempt to make other arrangements with Client as needed. Returned checks will be subject to a $_30_ fee and remittance of the original check amount with the additional fee will be due immediately in the form of cash or a money order. In general, it is important to discuss with Therapist any issues that arise in connection with our financial arrangements, so that they do not hinder the working relationship.

I have reviewed, understand, and agree to the stated policies regarding fees and payments _________.
Initials

5. **Telephone Accessibility**: Therapist is available via cellular telephone. Therapist does monitor her messages frequently and will make every effort to return Client's call within 24 hours of when Client makes it with the exception of weekends and holidays. If Client is difficult to reach, please leave some times when Client will be available. Therapist is unable to provide 24-hour crisis service. Should Client have a true clinical emergency that requires immediate attention or action; Client will need to call 911 or go to the nearest emergency room.

Therapist does not charge for telephone consultations that are less than 10 minutes. Consultations of greater length will be pro-rated based on Client's hourly fee. Should it become apparent that additional sessions are indicated, Therapist and Client will increase the number of weekly sessions as needed.

I have reviewed, understand, and agree to the stated policies regarding telephone accessibility _________.
Initials

6. **Termination of Therapy**: 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 also has the right to terminate therapy at his/her discretion, without any obligation, except for fees already incurred. Upon either party's decision to terminate therapy, Therapist will generally recommend that Client participate in at least one termination session. 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.

I have reviewed, understand, and agree to the stated policies regarding termination of therapy _________.
Initials

7. **Mediation and Arbitration**: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre- condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by Debbie G. Ramirez, LCSW and the client. The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Los Angeles County, in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. By signing this contract you are agreeing to have any issue of medical or psychological malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Debbie G. Ramirez, LCSW can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceeding shall be entitled to recover a reasonable sum as and for collection or attorneys' fees. In the case of arbitration, the arbitrator will determine that sum.

I have reviewed, understand, and agree to the stated policies regarding arbitration/mediation _________.
Initials

8. **Client Litigation**: 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 her self available for such an appearance at Therapist's usual and customary hourly rate of __$150.00_.

I have reviewed, understand, and agree to the stated policies regarding client litigation _________.
Initials

9. **Health Insurance & Confidentiality of Records**: Disclosure of confidential information may be required by your health insurance carrier in order to process claims. If you so instruct me, only the minimum necessary information will be communicated to the carrier. Unless authorized by you explicitly the Psychotherapy Notes will not be disclosed to your insurance carrier. I have no control or knowledge over what insurance companies do with the information I submit or who has access to this information.

You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies' computers and will also be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has been reported to have been sold, stolen, or accessed by enforcement agencies; therefore, you are in a vulnerable position.

I have reviewed and understand the stated policies regarding health insurance records_________.
Initials

10. **Confidentiality of E-mail, Cell Phone and Fax Communication**: It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify me if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices.

I have reviewed, understand, and agree to the stated policies regarding communication _________.
Initials

11. **Record Keeping**: Therapist may take notes during session, and will also produce other notes and records regarding 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 her 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.

I have reviewed, understand, and agree to the stated policies regarding record keeping _________.
Initials

12. **Partnership**: Finally, Client has the right to expect that Therapist will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with Client, all of which would greatly compromise our work together.

Therapy involves a partnership between Therapist and Client. As Client's therapist, Therapist will contribute knowledge, skills and a willingness to do her best. The determination of success, however, will ultimately depend upon Client's commitment to Client's own personal growth and care.

I have reviewed, understand, and agree to the stated policies regarding partnership _________.
Initials

Thank you for reviewing this information and please feel free to discuss any of this information with Therapist.

Client's signature below indicates that Client has read the above informed consent for services carefully, and understands and agrees to abide by all terms completely.

Print Name (Client) Date

Signature (Client) Date

Print Name (Additional Client) Date

Signature (Additional Client) Date

Print Name (Additional Client) Date

Signature (Additional Client) Date

Provider's Signature Date