Elizabeth Sullivan, LMFT

Psychotherapy for Individuals and Couples

582 Market Street, Suite 1509, San Francisco, CA 94104

Main: (415) 508-7086

License# 77529

PATIENT INFORMED CONSENT

I, Elizabeth Sullivan, am a Licensed Marriage and Family Therapy in the State of California. As such there are some policies and guidelines covered in this disclosure that it is important I share with you in order for our work together to be as effective as possible.

RISKS and BENEFITS:

Because therapy often includes discussing challenging aspects of your life, you may experience feelings such as anger, sadness, guilt, or frustration as a result. The process of focusing on these experiences with therapeutic support can be beneficial and can create changes in your life. Therapy is an investment in yourself and takes time.

Therapy may lead to better relationships, solutions to specific problems, and reductions in feelings of distress. The length of treatment will vary and will depend on your own goals and the complexity of the issues addressed. I welcome your questions or comments about our work together.

CONFIDENTIALITY:

The information discussed during your therapy sessions is confidential. Under the following specific circumstances I may be compelled or allowed by law or ethical guidelines to disclose confidential information:

• You are a danger to yourself or to the person or property of others, or unable to care for yourself. (Involuntary hospitalization may be required.)

• You make a serious threat of physical violence against a reasonably identifiable victim.

• I have a reasonable suspicion that a minor is the victim of neglect or sexual, physical, or emotional abuse, or an elder or dependent adult is the victim of abuse.

• My records are subpoenaed or my testimony is compelled, and I must comply with a court order.

• I am appointed by a court to assess you, to determine your sanity in a criminal proceeding, or to establish your competence under law.

• I must file a report that may become public (such as court-ordered psychotherapy within a drug-treatment program).

• You have introduced your mental or emotional state into a legal proceeding.

Other exceptions to confidentiality:

• During a course of couples or family therapy, when multiple family members are seen individually, confidentiality and privilege does not apply between the couple or between family members.

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• When minor children receive individual treatment with parent/legal guardian consent, parents/legal guardians are the holders of privilege; however, details regarding the treatment of your minor child/children may not be shared with you.

• If you, as a client of mine, are under sixteen years old and the victim of a crime.

• If, in the event of your death, our communications are important to establish your actions or intentions regarding your will or other disposition of property, or important to an issue between parties claiming through you.

• If you seek my services in order to enable yourself or another to commit a crime, or to avoid detection of or apprehension for a previous crime.

• If you make or threaten a legal, administrative, or ethical claim against me.

• If you default a fee due to me, I reserve the right to seek restitution through a third party, which would require disclosing that you had been my client and the balance of your outstanding fee(s).

Please note:

• If you are seeking insurance reimbursement, I will be required to acknowledge that you are my client, and some information may be given to your insurance company. If you plan to request a written receipt to submit to your insurance company for reimbursement, discuss this with me at the outset of treatment. 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.

• I may ask you to sign a Release of Information that will allow me to consult with a third party (for example, a physician, psychiatrist, former therapist, or family member), in the interest of furthering my work with you. If I am treating you as a couple, I need to obtain written consent from both of you before I am able to exchange information with any other party.

• To ensure quality service, I periodically discuss your therapy in consultation with other licensed professionals. In such cases, your name and other identifying information may be shared with other providers for the purpose of clinical collaboration. I may, with your permission, record some or all of our sessions, also for the purpose of improving my work and receiving feedback from consultants and colleagues.

• Progress notes of our meetings will be entered into my confidential files. You have the right to request to see the contents of your file at any time during therapy or immediately following termination of treatment, although I reserve the right to provide you with a summary of my notes and our therapeutic work together.

FEE:

My fee is due each session in the form of cash, check, or credit card. I reserve the right to increase my fees from time to time, and we will discuss together any planned fee change. Reduced fees may be negotiated based on financial need, and will be adjusted as circumstances change. You agree to pay $_____ per 50-minute session. You understand that there is a $25.00 charge for any non-sufficient fund (NSF) checks.

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COMMUNICATION:

Phone: If you need to talk with me between scheduled sessions, you may leave me a message at any time at (415) 508-7086. Please note that I will not necessarily be available in emergencies, and may require 24 hours before I am able to call you back. There is no charge for calls of less than 15 minutes. The charge for calls of 15 minutes or more is prorated based on your fee for a 50-minute session. In case of an emergency or if you cannot wait for me to return your call, contact your local crisis line, your family physician, or the nearest emergency room.

Psychiatric Emergency Services: **(415) 206-8125**
Mobile Crisis Team: **(415) 970-4000**
Comprehensive Child Crisis: **(415) 970-3800**
Westside Community Crisis: **(415) 355-0311**
S.F. Suicide Prevention: **(415) 781-0500**

Email: You may also send an email to: elizabethceceliasullivan@gmail.com. Please note that email, cell phone/text, and fax communication can be accessed by unauthorized individuals and, therefore, the privacy and confidentiality of such communication can be compromised. Email should be reserved for short communications regarding logistics only. If you are in need of longer communication we should schedule a phone call. If you cancel a session via email, please ensure that you get a confirmation message from me before assuming it is cancelled.

INSURANCE REIMBURSEMENT:

Superbills: Payment for therapy is made at the time of your visit. If you wish to receive reimbursement from your insurance carrier, I will provide you with an invoice of services on a monthly basis per your request. You must submit this invoice to your insurance company to receive reimbursement. For most carriers, I am considered an "out of network" provider. If you are considering using health insurance to cover the costs of therapy it is important to know that insurance companies, and plans, vary according to their coverage of mental health benefits. It is important, therefore, to research your coverage prior to commencing therapy.

SCHEDULING and CANCELLATION POLICY:

For therapy to be effective, weekly continuity is essential. When you make this commitment, I reserve a regular, ongoing appointment time for you. Therefore, this appointment time is not available as an open slot that I might offer to new clients or for rescheduling appointments. As a result, you may be charged for any session that is canceled with less than 48 hours notice. In case of sickness or emergency I am happy to reschedule your missed appointment the same week providing you can meet at a time I have available.

ENDING THERAPY:

Therapy comes to an end for a variety of reasons. If I propose the ending, it is typically because you seem to have accomplished your therapeutic goals. Occasionally I feel that a client would be better served with a different professional. I also reserve the right to end therapy if a client does not adhere to these policies. You may withdraw from therapy at any time. If you begin to feel that you need to or would like to end therapy, for whatever reason, please discuss this with me as soon as possible. Closure in psychotherapy is important, and it is almost always in your best interest to schedule a few sessions prior to a mutually agreed-upon termination date.

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BY SIGNING BELOW YOU AGREE TO THESE POLICIES AND GIVE CONSENT TO ENGAGE IN TREATMENT WITH ME.

Name (please print): _____

Address: _____

DOB: _____ Confidential Phone Number: _____

Email:_____

Emergency Contact Name:_____ Phone number:_____

Signature: _____Date: _____

* * * * * * * * * * *

Name (please print): _____

Address: _____

DOB: _____ Confidential Phone Number: _____

Email:_____

Emergency Contact Name:_____ Phone number:_____

Signature: _____Date: _____