**Dr Jackie PLLC**

Jacqueline Sabarese, PhD, JD

8208 Venosa Haven Terrace

Boynton Beach, FL 33473

Website: DrJackiewellness.com

Phone: 561-423-1811

**INFORMED CONSENT FOR PSYCHOTHERAPY**

THE PROCESS OF THERAPY AND SCOPE OF PRACTICE:

Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working towards these benefits requires effort on your part, including active involvement, honesty, and openness. During therapy, remembering and talking about unpleasant events, thoughts, or feelings can result in experiencing considerable discomfort or strong feelings of anger, sadness, fear, etc. Attempting to resolve issues that brought you to therapy may result in changes that were not originally intended. Sometimes a decision that is positive for one family member may be viewed negatively by another family member. No particular outcome can be guaranteed. As with any healing process, you may temporarily feel worse before feeling better. Be assured that psychotherapy has been found helpful in a long tradition of scientific research. In general, sessions are initially scheduled on a weekly basis. Within a reasonable time after the initiation of treatment, I will discuss with you a working understanding of the presenting problem(s), treatment plan, therapeutic objectives, and your view of the possible outcomes of treatment.

Please be advised the following services do not fall within the scope of my practice: medication recommendation or prescription, legal advice, or custody evaluation recommendations.

PROCESS: During the initial phase of treatment, I will assess if I can be of benefit to you. If I determine that you have needs that surpass my practice expertise or scope of services, I will provide you several referrals whom you can contact. I believe that goodness of fit between therapist and client is essential to the therapeutic process. You have the right to seek a second opinion from a different therapist and to terminate therapy at any time. If you decide to end therapy, I ask that you discuss your intentions with me first. If appropriate, I will provide you with names of other qualified professionals, and with written consent, will provide them with the essential information for continuity of care at your request. If you decide to stop therapy without discussion, after 90 days your file will be closed. In certain circumstances, I may decide to terminate therapy after discussing the reasons for my decision with you. If I determine that I am not effective in helping you reach your therapeutic goals, if you are non-compliant with the treatment plan or chronically cancel or miss appointments, if a conflict of interest or dual relationship develops, or if you harm or threaten to harm this practitioner or those close to this practitioner, therapy may be terminated involuntarily. It is my intention that termination of therapy will be mutually agreed upon based on the satisfactory completion of the treatment plan and attainment of your stated goals of therapy.

CONFIDENTIALITY AND PRIVILEGED COMMUNICATIONS:

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law. According to Florida Statue, section 490, this privilege may be waived under the following circumstances:

* When there is a reasonable cause to suspect that a child, dependent, or elderly person is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for their welfare.
* When there is a clear and immediate probability of physical harm to the client, to other

individuals, or to society and the therapist communicates the information only to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

* When the therapist is a party defendant to a civil, criminal, or disciplinary action arising

from a complaint filed by the client, in which case the waiver shall be limited to that action.

* When the client agrees to the waiver, in writing, or when more than one person in a family is receiving therapy when each family member agrees to the waiver, in writing.

Disclosure may also be required:

* Pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records.
* By your health insurance or managed care plan if you request that they make payment on your behalf.
* In the event that I am incapacitated or suddenly ill. A professional colleague of mine will contact you.

EMERGENCY SITUATIONS: If there is an emergency during therapy, where I become concerned about your personal safety, the possibility of you injuring yourself or someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may contact the person whose name you have provided on the Client Intake Form.

TELEPHONE AND EMERGENCY PROCEDURES:

If you need to contact this therapist between sessions, please leave a voicemail message at (561) 423-1811 and your call will be returned as soon as possible. I check messages during regular work hours only, unless I am out of town. If an emergency situation arises, please call 911 or go to the nearest hospital emergency room. You may also contact Columbia Hospital (561) 881-2671, JFK North Behavioral Services Unit (561) 881-2671, or the National Crisis Hotline 1 800-273-8255 available 24/7.

LITIGATION LIMITATION:

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on this therapist to give a deposition, testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

STANDARD SERVICE FEES:

The rate for a 45 minute session is $150. If a report, letter or consultation with an outside party is requested, I understand I will be billed for any time required to prepare documentation, or to conduct an in-person or phone consultation. The standard service fee listed above will apply.

FORMS OF PAYMENT AND PAYMENT POLICIES:

The following forms of payment are accepted: cash, check, and credit cards. Clients will be responsible for payment at the time services are rendered. Checks returned for insufficient funds will be charged $25 in addition to the amount of the check. An invoice may be sent to your home for any outstanding balance.

CANCELLATION POLICY:

If you need to cancel an appointment, 24 hour advanced notification is required. This allows your session time to be offered to another client. If you do not give sufficient notice or no notice is given at all, you will be charged a $50 fee. You will be personally responsible for this fee. Emergency circumstances leading to late cancellations or missed appointments will be taken into account.

MINORS:

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the child’s other parent, please be aware that I may notify the other parent that I am meeting with your child, as parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

If I meet with you or other family members in the course of your child’s treatment, I will make notes of that meeting in your child’s treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child’s treatment record.

It is my policy to provide you with general information about your child’s treatment, but NOT to share specific information your child has disclosed to me without your child’s agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child’s risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

My role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent’s custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $ 300.00 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child/AdolescentPatient:

Minor’s Signature\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_