INFORMATION ABOUT PSYCHOLOGICAL TREATMENT

1. **CONFIDENTIALITY:** Allinformation disclosed within your psychotherapy sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except when disclosure isrequired by law. Most of the provisions explaining when the law requires disclosure are described in the “Notice of Privacy Practices” that you received with this form.
2. **WHEN DISCLOSURE IS REQUIRED BY LAW:** Some of the circumstances where disclosure is required by law are (1) where there is a reasonable suspicion of child, dependent or elderabuse or neglect; and, (2) where a client presents a danger to self to others, to property, or (3) is gravely disabled (for more details see also “Notice of Privacy Practices” form).
3. **WHEN DISCLOSURE MAY BE REQUIRED:** Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by you. In couple, family therapy, or group treatment or when different family members are seen individually, confidentiality and privilege donot apply between thecouple, group or among family members. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless he is authorized to do so by all adult family members who were part ofthe treatment.
4. **CONFIDENTIALITY OF MEDICAL INFORMATION WHEN TREATING A MINOR CHILD**: Parents and legal guardians have the legal right to access confidential medical information pertaining to a minor child with a few exceptions based on state and Federal law. However, in the interests of developing trust, rapport and a good therapeutic relationship, when seeing a minor child, I prefer to use my clinical judgment in determining what types of communication should be made to parents or legal guardians. In general, I may choose to restrict releasing clinical information to parents to the following (1) general information and psychoeducation about the nature of the problem and treatment being considered, (2) discussions of immediate safety and health concerns that may jeopardize the well being of the minor, including significant risk of suicidality, dangerousness to others, or other behavior that is an immediate risk to health or safety, (3) any other information that will be beneficial to the treatment of the child.
5. **EMERGENCIES:** Ifthere is an emergency during our work together, or in the future after termination, where I become concerned about your personal safety, the possibility of you injuring 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 also contact the police, hospital or the person whose name you have provided as an emergency contact or other persons previously identified by you.
6. **HEALTH INSURANCE AND CONFIDENTIALITY OF RECORDS:** Disclosure of confidential information may be required by your health insurance carrier in order to process claims. Only the minimum necessary information will be communicated to the carrier. I have no control over what insurance companies do with the information 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 computers are inherently vulnerable to break-ins and unauthorized access.
7. **CONFIDENTIALITY OF E-MAIL, CELL PHONE AND OTHER COMMUNICATIONS:** E-mail and cell phone communication can be 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. Please notify me at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication methods. I can provide a secure, encrypted email service (Virtru) that is HIPAA compliant. Please never use e-mail or faxes to communicate with me in emergency situations.
8. **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, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.
9. **SESSION RECORDINGS AND CONSULTATION:** I routinely make recordings of my sessions and consult regularly with other professionals regarding my clients for training, supervision, and other purposes; however, your name or your identifying information is never mentioned.
10. **USE OF ONLINE TOOLS, MOBILE APPS** **AND** **VIDEOCONFERENCING**: Dr. Reiser may suggest that you use an online tool or a mobile application to record assessment related information related to your treatment. Under certain circumstances, he may suggest a meeting via video. He uses a professional version of Zoom designed to safeguard your confidentiality and to meet HIPAA security standards (e.g., encrypted data transmission). However, if you do use one of these tools, confidentiality cannot be completely guaranteed, and you agree to accept the risk that a breach of confidentiality may occur. It is also possible that that Dr. Reiser may be less helpful than usual because he will have less information than when you and he are in the same room; and, video meetings are vulnerable to interruptions and technical difficulties.
11. **TELEPHONE CONTACT & EMERGENCY PROCEDURES:** If you need to contact me between sessions, please leave a message on his business cell phone 415-297-1016 and your call will be returned as soon as possible. I check my messages a few times a day (but never during the night time). I check my messages less frequently on weekends and holidays. If an emergency situation arises, please indicate it clearly in your message. I will not be able to handle immediate emergencies that may arise during the course of treatment. If you need to talk to someone right away, you can call the Marin County Crisis Line at 499-1100, or 415 473-6666 for the 24-hour Psychiatric Emergency Service for Marin County. In Santa Clara County for the Suicide and Crisis Hotline call 1-855-278-4204 or call 911 for any life-threatening emergency.
12. **PAYMENTS AND INSURANCE REIMBURSEMENT:** Clients are expected to pay the standard fee of $180 per 45 minute session at the beginning of each session. For our extended 90 minute initial assessment session you will be charged $350. You may make payments by check or credit card. A minimum of 72-hour notice is required for re-scheduling or canceling an appointment**.** You will be charged the full appointment fee if you cancel or reschedule without 72 hours’ notice. **By signing this agreement, you also agree to provide me with an authorization to charge your credit card for any missed or cancelled appointments.** Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. may be charged at the same rate, unless indicated and agreed otherwise. Please let me know right away if any problem arises during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company. It is your responsibility to verify the specifics of your coverage. Upon request, I will provide you with a monthly statement of services provided, which you can then submit to your insurance company for reimbursement if you so choose. Not all issues/conditions/problems, which are the focus of psychotherapy, are reimbursed by insurance companies.
13. **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 mutual agreement of Dr. Reiser and his client(s). 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 Marin County in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, I can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorneys’ fees. In the case of arbitration, the arbitrator will determine that sum.
14. **THE PROCESS OF THERAPY/EVALUATION:** 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 toward these benefits, however, requires effort on your part. Psychotherapy requires very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior, I will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly.

During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it can be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, I am likely to draw on various psychological approaches according to the problem that is being treated and his assessment of what will best benefit you. These approaches include cognitive-behavioral, behavioral, system/family, or other psycho-educational interventions.

1. **DISCUSSION OF YOUR TREATMENT PLAN:** Within a reasonable period of time after beginning treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks and benefits, my expertise in employing them, or about the treatment plan, please feel free to ask additional questions. I will make every effort to respond to your concerns fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.
2. **EVALUATION OF YOUR TREATMENT:** I am committed to evaluating the outcomes of treatment with you, and for this purpose, will ask you to complete a number of assessments of problems or symptoms at the beginning of treatment, periodically and at the end of treatment. I use a HIPAA compliant service called PsychSurveys that sends you an email notice to complete surveys to the email address you have given me. To complete these surveys you will be asked to log in to the PsychSurvey website. These surveys will be sent periodically to help me evaluate the progress of our work together.
3. **TERMINATION:** After a series of initial meetings, I will make an assessment as to whether I can be of benefit to you**.** I do not accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals that you can contact. If at any point during psychotherapy, I believe that I am not being effective in helping you reach your therapeutic goals, I will discuss this concern with you and, if appropriate, we may decide to terminate your treatment. I will give you a number of referrals that may be of help to you. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional’s opinion or wish to consult with another therapist, I will assist you in finding someone qualified, and, with your written consent, I will provide essential information needed. You have the right to terminate therapy at any time. If you choose to do so, I will offer to provide you with names of other qualified professionals whose services you might prefer.
4. **CANCELLATION: A minimum of 72-hour notice is required for re-scheduling or canceling an appointment.** The full fee of $180 for a 45 minute session will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

**I have read the above agreement about office policies and information about psychological treatment carefully. I understand them and agree to comply with them.**

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**Client name (print) Date Signature**

**(or Legal Guardian if Minor)**

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**Therapist Date Signature**