**PSYCHOTHERAPY INFORMED CONSENT**

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Patient Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The following information is provided to you so that you have a better understanding of how your care will be provided. Should you have any questions or concerns about my policies, please ask me so that we can discuss them.

**CONFIDENTIALITY:**

All information between therapist and patient is held strictly confidential unless:

1. patient authorizes release of information with his/her signature.

2. patient presents a physical danger to self.
3. patient presents a danger to others.

4. child/elder abuse is suspected.

5. patient fails to pay for services rendered and formal collection becomes necessary.
I am required by law to inform potential victims and legal authorities so protective measures can be taken in the case of significant risks to others.

**FINANCIAL TERMS**

If you are a member of an insurance plan of which I am a covered provider, I will bill your insurance company directly and you will be responsible for any applicable **deductibles** and **copayments**. Deductibles frequently renew at the beginning of the calendar year, and you will be responsible for the full contracted fee until your deductible is met. I am happy to check your insurance benefits and provide you with details at any time. In addition, you can always call the member services number on your insurance card to verify. Please note that if your eligibility for benefits lapses, you will be responsible for full payment of my fee of $165 per session.

Should I be required to testify or participate in any legal matter on your behalf, the fee for my time is three times my normal rate, or $495 per hour.

**Copayments must be paid at the time services are rendered by cash or check**. **If you wish, I can also keep a credit card on file, in which case I will bill on a monthly basis.**

**CANCELED/MISSED APPOINTMENTS**

* You may cancel or reschedule an appointment at any point up to 24 hours prior to the scheduled appointment. A psychotherapy appointment means that time is reserved only for you. ***If an appointment is missed or canceled with less than 24 hours notice, you will automatically be billed a cancellation fee of $75 (not your copayment) as insurance companies will not cover missed appointments****.*
* Please note that this cancellation policy is important for my psychotherapy practice because, while a medical doctor can see 35 patients in a day, a therapist generally sees a maximum of 6 or 7. I reserve for you, and all my clients, a full hour of my time for the session and clinical notes. If you cancel with less than a full 24-hour notice, I most likely will not be able to fill that time slot, and I will lose an entire hour from my work schedule. Sometimes there are also patients who have an urgent need to see me, whom I must turn away due to lack of appointment availability, but when I have adequate notice of an opening, I may be able to fit them in.

My patients know that my cancellation policy in not a penalty or a punishment. Truth be told, if you are in counseling long enough, at some point you might forget about an appointment, or something will come up in your schedule that will result in you missing an appointment. Perhaps you will need to work late, have a sudden onset of the flu, or something else unavoidable will come up.

I’m never upset with clients when they miss an appointment. I understand that’s life.

I am fortunate in that my clients are fully on board with this policy, and this makes life so much easier for my clients and me. As part of this consent form, I need your consent and agreement that if or when the day comes that you miss an appointment, for any reason, you will gladly pay the $75 cancellation fee for the missed appointment, just like you pay for the sessions you attend.  If you have any concerns about this policy, please let me know so that we can discuss them.

***For billing purposes, please provide your credit card details below in the event of a late cancellation/missed appointment:***

Credit Card No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Expiry Date\_\_\_\_\_\_\_

Security Code\_\_\_\_\_\_\_\_\_\_Billing Zip Code\_\_\_\_\_\_\_\_\_

Do you wish to have your card billed on a monthly basis for sessions, or would you prefer to bring cash or check to each appointment? (Choose one of the following):

Pay by credit card monthly\_\_\_\_\_ Use the credit card above or a different card? \_\_\_\_\_

Pay by cash/check on a per session basis\_\_\_\_\_\_

**URGENT PROCEDURES**

If you need to contact me urgently, call me cell phone (323) 697-0304 and leave a message if necessary, and your call will be returned, typically within the hour. If you experience a true life-threatening emergency and need immediate attention, you should call 911 or go to the nearest hospital emergency room, then leave a message for me at your earliest convenience.

**RELEASE OF INFORMATION TO HEALTH PLAN**

I authorize release of information regarding my care to my health plan for the payment of claims, certification/case management decisions and other purposes related to the administration of benefits for my Health Plan.

**CONSENT FOR TREATMENT**

I further authorize and request that my treating provider carry out psychological examinations, treatments, and/or diagnostic procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that, while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

**ASSIGNMENT OF BENEFITS**

I authorize payment of medical benefits directly to my therapist.

SIGNED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand and agree to all of the above information.