

Informed Consent and Disclosure Statements

Welcome to my practice. This document contains important information about my professional services and policies. Please read the entire document carefully and ask any questions you have regarding its contents.

Information About Me

Prior to beginning treatment, I will discuss my professional background and provide you with information regarding my experience, education, special interests, and professional orientation.

I am an LMFT, license number 117097.

Information About This Practice

This practice is a sole proprietorship. The name of this business is Meghan Todd Therapy. I am the sole owner and operator of this practice.

About the Therapy Process

It is my intention to provide services that will assist you in reaching your goals. We are partners in the therapeutic process. As partners, we will work together to develop a plan for your treatment. Based on the information you provide to me and the specifics of your situation, I will offer feedback and recommendations regarding your treatment and progress.

Over the course of therapy, I will attempt to evaluate whether the therapy provided is beneficial to you. While I hope our work together will be effective, the amount and length of treatment varies from patient to patient. I am unable to predict how long you will be in therapy or guarantee a specific outcome or result of our work together.

Therapy sessions are approximately 50 minutes each. Typically, sessions are scheduled once per week, at the same day and time each week. Consistent attendance contributes greatly to a successful outcome.

Fees and Insurance

The fee for service is \$150 per individual therapy session.

The fee for service is \$200 per conjoint (couples /family).

Fees are payable at the time that services are rendered. I accept payment in the form of debit or credit card via online transactions. It is my goal to maximize your session time. Therefore, I will collect and/or provide the necessary billing information ahead of time.

You are ultimately responsible for payment for services received, even if you are relying on, or expecting your insurance company or another third-party payor to cover the costs of your treatment. I will notify you in the event of any changes to fees or when other charges are to be applied. If you are experiencing financial difficulty, please let me know so we can discuss your options for care.

I do not accept insurance. I am a private pay/cash pay business only. However, I am happy to provide you with a superbill (a.k.a. a receipt for services) which you can submit to your insurance for potential reimbursement. Depending on the terms of your health coverage, your plan may or may not reimburse for out-of-network services.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur once per week on the same day at the same time, if possible. I may suggest a different amount or frequency of therapy depending on the nature and severity of your concerns. Your consistent attendance can greatly contribute to a successful therapy outcome. To cancel or reschedule an appointment, please notify me at least 48 hours in advance of your appointment. If you do not provide me with at least 24 hours' notice of a cancellation, I will charge you the full fee for the missed session.

Your Right to Confidentiality

As a psychotherapy patient, you have a right to confidentiality with respect to information related to our work together. Accordingly, information shared between us will generally remain confidential.

Exceptions to Confidentiality

In certain, limited instances, the law requires me to disclose information pertaining to my work with you. For example, as a therapist I am required to report suspected child, elder, and dependent adult abuse. Please note that the legal definition of "child abuse" generally includes instances of "sexting" in which a person *of any age* captures, records, sends, receives, or possesses an image or video depicting a minor engaged in sexual or otherwise obscene conduct.

Similarly, in the event that I believe you present a serious and imminent danger to yourself, another person, or the public, I may be required to disclose information to emergency medical services, law enforcement, and/or another third party that can help to reduce or prevent that danger.

Confidentiality and Treatment of Minors

If a minor's parent(s) or guardian(s) give consent for me to treat the minor, I typically provide the parent(s) or guardian(s) with general updates about the minor's treatment. These updates may include the minor's diagnosis, treatment plan, progress in therapy, session attendance, or similar information. However, I generally do not share specific details about the minor's treatment or what the minor has shared with me during sessions unless: 1) the minor gives me permission to disclose such information and I believe the disclosure would be clinically appropriate; or 2) the minor is experiencing a crisis or other emergency circumstance that would authorize me to break confidentiality.

If the minor consents to their own treatment, the law generally prohibits me from communicating with their parent(s) or guardian(s) without written authorization from the minor unless the minor is experiencing a crisis or other emergency circumstance that would authorize me to break confidentiality.

Please feel free to reach out to me if you have questions about these policies or if you would like to discuss them further.

Confidentiality and Couples / Family Therapy

If you are participating in couples or family therapy, please be aware that, in most circumstances, the law prohibits me from disclosing confidential information and records regarding the unit of treatment's services unless *all* identified patients provide written authorization to release the information.

I would also like for my couples and family therapy patients to be aware that I utilize a "no-secrets" policy. This means, when I determine it is clinically appropriate or necessary to do so, I am able to disclose information I obtain from one member of the couple, or a participating member of the family therapy unit, (i.e. the "treatment unit") with the other member(s) of the treatment unit. This policy also applies to information a member of the treatment unit shares with me outside of couples / family sessions (e.g. via email, text, etc.) and information I obtain during individual session(s) with a member of the treatment unit (should we agree to hold individual sessions in

furtherance of your couples / treatment goals). I find that this policy facilitates effective communication with and between my couples and family therapy patients. It also helps me to avoid potential problems which may arise when a therapist is perceived to be “keeping secrets” from other members of the treatment unit.

My Communication With You

From time to time, I may need to communicate with you outside of our sessions together to discuss scheduling, payment, or other issues related to your treatment. To respect your privacy, it is important for me to understand your communication preferences. Please indicate your openness to receive communication from me via the following methods:

Phone

My Cell Phone Number is _____

- I authorize my therapist to call me at this number
- I authorize my therapist to leave messages for me at this number

Additional Information About Unencrypted Text Messaging: I value your privacy and take appropriate steps to preserve the confidentiality of information shared between us. However, it is important to be aware that certain risks may still be present when communicating via unencrypted text, such as technological failures or unintended access by third parties.

- I understand the information above and authorize my therapist to communicate with me via unencrypted text using the cell phone number I provided.

Email

My Email Address is _____

Additional Information About Unencrypted Email: I value your privacy and take appropriate steps to preserve the confidentiality of information shared between us. However, it is important to be aware that certain risks may still be present when communicating via unencrypted email, such as technological failures or unintended access by third parties.

- I understand the information above and authorize my therapist to communicate with me via unencrypted email at the email address I provided.

Mail

My Home Address is _____

- I authorize my therapist to send necessary, treatment-related information to me at this address.

Additional Communication Information and Preferences

Please feel free to inform me if there are additional communication preferences you would like for me to be aware of, or if you do not wish to be contacted at a particular time, place, or by a particular means.

I will do my best to honor your communication preferences, but please be aware that in certain instances, such as emergency circumstances, I may need to reach you through other methods.

Emergency Contacts

It is critical for me to know who I can contact in the event that you are experiencing a medical or psychiatric crisis

or other emergency circumstance. Please identify these individuals in the space provided below:

Emergency Contact 1

Name _____
Relationship to Patient _____
Home Phone Number _____
Cell Phone Number _____

Emergency Contact 2

Name _____
Relationship to Patient _____
Home Phone Number _____
Cell Phone Number _____

Emergency Contact 3

Name _____
Relationship to Patient _____
Home Phone Number _____
Cell Phone Number _____

Your Communication With Me

My Contact Information

Outside of our sessions together, my preferred methods of communication are as follows:

Phone: (510) 214-2345

Email: meghan@meghantoddtherapy.com

You may text, call, or email. I will do my best to respond as soon as possible, and will definitely respond within 48 business hours.

Urgent / Emergency Communications

If you are ever experiencing a medical or psychiatric emergency or if you are facing an emergency involving a threat to your safety or the safety of someone else, please call 911 to request emergency assistance. In the event of a mental health crisis, you may also call the 988 Suicide & Crisis Lifeline by dialing “988.” In the case of domestic/intimate partner violence, text “START” to 88788.

Therapy Across State Lines

Unfortunately, I may not be able to treat you while you are physically outside of the state of California. My ability to do so depends on various factors, such as the laws of the jurisdiction you will be traveling to. If you know you will be traveling outside of the state, please provide me with as much advance notice as possible so I may have enough time to determine whether I will be able to provide treatment to you during that time.

If I am unable to treat you while you are outside of California, we can discuss alternative care options and

strategies as well as what you should do in the event of an emergency.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on your clinical needs, the specifics of your treatment plan, and the progress you make towards achieving your treatment goals. While I hope you will find our time together beneficial and meaningful, I cannot guarantee the specific outcome(s) or result(s) your treatment will yield.

You may discontinue therapy at any time. If one of us determines you are not benefiting from treatment, we can discuss treatment alternatives. These alternatives may include, among other possibilities, changes to your treatment plan, referrals to other therapists, and/or termination of treatment.

Accommodations

If you have a disability and require accommodation presently or at any time during the course of treatment, please contact me.

Questions About My Policies

Please let me know if you have any questions about my policies or if you would like to discuss them further.

Informed Consent

Your signature below indicates that you have read this agreement for services and disclosures carefully, understand its contents, and consent to receive treatment from me.

Name

Patient's Name (If You Are Not the Patient)

Relationship to Patient (If Applicable)

Signature

Date