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CONSENT TO TREATMENT

Welcome to my psychotherapy practice. This document contains important information about my professional services and policies. Please read it carefully and note any questions you have so we may discuss them together. When you sign this document it will represent an agreement between us.

ABOUT PSYCHOTHERAPY: Psychotherapy is a collaborative process between therapist and client. Progress depends on many factors including but not limited to motivation, effort, your support system, and biological factors. Unlike certain types of doctor's visits psychotherapy calls for active participation on your part. Length of treatment varies depending on the nature and severity of the issues you are facing as well as the previously mentioned factors.

While therapy is intended to be helpful, it may at times feel difficult or uncomfortable. This does not necessarily mean that therapy is not working. In fact, it may mean that we are touching on some important underlying factors that need our therapeutic attention. Personal change and benefits of treatment typically occur gradually with regular attendance over time, though there are no guarantees of what you will experience. Your participation in therapy is voluntary and you may choose to discontinue treatment at any time. However, I strongly encourage you to take the time to discuss your feelings about therapy and the therapeutic relationship with me so that we can collaborate on deciding the best course of treatment for you. If at any time you wish to have another professional opinion or to seek treatment elsewhere, I can refer you to other qualified professionals.

CONFIDENTIALITY: Under most circumstances all communication between client and therapist is confidential. However, under the following

circumstances California state law requires psychologists to disclose information:

1. If the therapist has reasonable suspicion of child abuse/neglect or abuse of a dependent/disabled adult or elder, a report must be made to the designated agency.
2. If a client threatens and intends to harm self or is unable to care for self, the therapist may be obligated to seek hospitalization for the client and/or to contact family members or others who can provide protection.
3. If a client communicates to the therapist a serious threat to harm an identifiable person or group of people, the therapist is required to take protective actions including notifying the potential victim(s), contacting the police, and/or seeking hospitalization for the the client.
4. In the event of a court order treatment information and records may have to be provided.

Should you become involved in legal proceedings, I request that neither you nor your attorney, nor anyone else acting on your behalf, call on me, Dr. Castro, to testify in court or at any other proceedings. In addition, I ask that a disclosure of psychotherapy notes/records not be requested of me.

I consult professionally and confidentially with colleagues and will conceal your identity in any consultations I seek.

PAYMENT FOR SERVICES: Once we have agreed to proceed with treatment I will typically bill you at the end of each month and request that you provide payment within seven days of receiving your billing statement. I generally have a small fee increase at the beginning of each calendar year. I will discuss this with you in advance.

In the event of frequent or extended communications that occur outside of scheduled sessions I will bill at a rate equivalent to my hourly fee. The same will apply should you request other professional services from me such as preparation of records or treatment summaries, letter/report writing, attendance at meetings with other professionals you have requested /authorized, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that

require my participation, you will be expected to pay for my professional time even if I am called to testify by another party.

You will be responsible for verifying out-of-network coverage with any third party payers and for completing most insurance-related phone calls and paperwork. If you request, I will provide your insurance company with information necessary for you to receive reimbursement for your therapy. Please note that this will require my providing a diagnosis code to your insurance.

CANCELLATION POLICY: I ask for a minimum notice of one week for cancellations. However, I ask that you give me as much notice as possible for planned absences. If you need to reschedule I will do my best to offer you another time within the same week, if my schedule permits. If you cancel with less than one week's notice and we are not able to reschedule within the same week I will bill for the missed appointment. I will give you advance notice of any planned time away from the office that will affect your scheduled sessions with me.

CONTACT AND EMERGENCY PROCEDURES: You may contact me using my office voicemail, my cell phone voicemail or text message, and by email. Please keep in mind that text and email messages may not be private or secure modes of communication, and should only be used for brief exchanges related to scheduling or other logistics.

I check messages periodically throughout the day, but I often am not immediately available. I will make every effort to get back to you as soon as possible, especially in the event of an urgent matter. I generally do not check messages in the evening/at night and may check messages just once or twice a day on weekends and holidays. When I am on vacation I will typically provide the name and contact information of a colleague who can be contacted should you urgently need to speak with someone while I am away.

In the event of an immediate crisis or emergency you should leave me a message and then call SF Psychiatric Emergency Services (24 hours a day) at 415-206-8125 or The Marin County Crisis Stabilization Unit at 415-473-6666 or the police at 911.

Your signature below indicates that you have read, understood, and agree to the polices set forth in this Consent to Treatment statement.

_____

Printed Name

_____ _____

Client Signature Date