CONSULTANTS FOR CHANGE

733 E. Chapman Avenue
Fullerton, CA 92831
(714) 992-4656

Informed Consent for Psychotherapy Assessment Consultation

Your Name _____

Address _____

Day Phone _____ Night Phone _____

Referred by _____

Reason for seeking consultation _____

The hourly fee for the initial Assessment Consultation sessions is $_____ to be rendered *at the time of service*. Twenty-four hour cancellation is required to avoid being charged for scheduled appointments.

The purpose of these sessions is to determine your needs and to help you decide what form(s) of psychotherapy consultation may be desirable. These sessions are for assessment only. Any other psychological or counseling services are offered under a separate fee schedule and service agreement.

Your therapist will provide you with a paid receipt for these initial sessions suitable to be presented to your insurance carrier or to your managed care company. Contact your insurance representative for information on whether these sessions are covered. Please note that extended treatment and couple or family counseling is usually not a managed care benefit.

I agree to pay all legal fees that might be incurred by the therapist as a result of these assessment sessions.

Confidentiality
I understand that in some instances my confidentiality is limited by law. If I inform Dr. Kaisch of child abuse, elder abuse, or the abuse of dependent adults, or situations in

which serious physical harm is threatened toward oneself or toward someone else, Dr. Kaisch must report this to the authorities and to any intended victims as mandated by law. In addition, all forms of electronic communication such as texts, emails and cell phone calls are not confidential.

Release of Confidential Information
Are you currently in therapy? Yes No

If so, who is your current therapist?
Name _____ Phone _____

Who are your past therapists?
Name _____ Phone _____
Name _____ Phone _____
Name _____ Phone _____

Who is your current psychiatrist?
Name _____ Phone _____

Do you give Dr. Kaisch permission to contact your current and/or previous therapists/psychiatrist to obtain information that would be helpful during these initial assessment sessions. Please initial Yes ____ or No ____

Professional ethics require that therapists obtain pertinent records from current and previous psychotherapists and physicians in order to work effectively with you. Should you decide to continue services beyond a few assessment sessions, an Informed Consent for Dynamic Psychotherapy will be provided and agreed upon.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

ALL THERAPISTS IN THIS BUILDING MAINTAIN INDEPENDENT PRACTICES.

A PHOTOCOPY VERSION OFTHIS FORM IS AS VALID AS THE ORIGINAL