## **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 Consultarendered at the time of service. Twenty-four hour charged for scheduled appointments.	<del></del>	
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 Name Name	Phone	
Who is your current psychiatrist? Name	Phone	
Do you give Dr. Kaisch permission to contact therapists/psychiatrist to obtain information the assessment sessions. Please initial Yes	hat would be helpful during these initial	
Professional ethics require that therapists ob previous psychotherapists and physicians in you decide to continue services beyond a fev Consent for Dynamic Psychotherapy will be	order to work effectively with you. Should wassessment sessions, an Informed	
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