Carolyn E. Taylor, Licensed Marriage and Family Therapist
291 W. 12th Avenue, Eugene, OR 97401
Oregon MFT License # T1422 California License MFC # 53963
carolyntaylor.mft@earthlink.net 213-804-5699 www.carolyntaylortherapy.net

INFORMED CONSENT TO RECEIVE PSYCHOTHERAPY

NATURE OF SERVICES

I understand that I am consulting Carolyn Taylor, a Licensed Marriage and Family Therapist, for provision of psychological services. I understand that therapy is intended to reduce or eliminate psychological symptoms, and improve academic, workplace and social/relational functioning. Psychotherapy often leads to substantial improvement but the process may be uncomfortable at times, including experiencing painful feelings such as anger, sadness, and anxiety. I am aware of these potential risks, and I consent to treatment.

CONFIDENTIALITY

I understand that information I reveal within sessions remains confidential unless disclosure is required by law. I understand that exceptions to confidentiality occur in the following circumstances: if I convey to my therapist a reasonable suspicion of child, dependent adult, or elder abuse; if I indicate that I may be a danger to others, or that I am likely to harm myself (and if I am not voluntarily amenable to protective measures). I further understand that, on occasion, it may be helpful for my therapist to consult with a colleague; if so, I understand that my identity will be concealed. I am aware that if I enter my emotional status as an issue in any legal proceeding (e.g., disability claims, divorce proceeding, child custody evaluation), then I will be waiving my right to the confidentiality of our sessions. Also, if I apply for insurance reimbursement for my psychotherapy, I understand that they will require a diagnosis, just as they would with any other health provider. Finally, I understand that the Patriot Act has the authority to override confidentiality if information about me were to be applied under its jurisdiction and that the Patriot Act also forbids a therapist from letting a client know of any such information demand.

APPOINTMENTS AND CANCELLATIONS

I understand that regular individual sessions are 50 minutes long but that I may request a longer session time (75 or 90 minutes) when needed, and that my therapist will do her best to accommodate my request, with the fee increasing in proportion to the additional time. I am aware that regular attendance is important to effective therapy and that, if I am late, the session will still end at the regular time. I know that I am responsible for my scheduled appointment each week - and that, if I cannot attend, I will cancel at least 24 hours in advance. If I cancel with less than 24 hours' notice, I know I will be charged for the session.

PAYMENT FOR SERVICES

I understand that the present fee for therapy is $_____ per _____ - minute session, by cash or by check made out to Carolyn Taylor. I understand that any bank charges on returned checks are my responsibility, and that delinquent accounts will be referred for collection. I am aware that over time the fee may be increased, but I will be given at least one month advance notice of any such change.

INSURANCE REIMBURSEMENT

I understand that my health insurance will not be billed directly but that I may request a monthly statement for my records and for health insurance claims (aka a "superbill"), which I can submit to my insurance company for reimbursement. However, I understand that I am personally responsible for all charges and am required to submit these claims on my own. I understand that my therapist will provide whatever other assistance that is needed to obtain reimbursement.

CONTACTING MY THERAPIST

I am aware that I can leave Carolyn a voicemail, text or email 24 hours a day at the above designated contacts, and that I will clarify if I wish a callback/reply or just wish to voice feelings, etc. I will leave the best contact(s) and best times to reach me. I understand that I will be reaching an answering machine where I can leave a confidential message. I know that I can email or text her for matters such as scheduling, but I recognize that confidentiality via electronic communication is never guaranteed. I understand that Carolyn will make every effort to return my call on the day I make it and usually within 4 hours or less. If I seek an urgent reply, I will specify this in my message. If the call concerns an emergency, I understand that I should contact 911, my family physician, or local emergency room and ask for the psychologist or psychiatrist on call. I also understand that if I do not hear back from Carolyn in the anticipated time frame, I will phone, text, or email again – preferably by an alternate mode given that technology may have glitched receipt of the first message.

PROFESSIONAL RECORDS

I understand that both the law and professional standards require that appropriate written records of services provided to me will be maintained. I understand that the confidentiality of these records is closely safeguarded (under lock and key).

RELEASE OF INFORMATION

Finally, I understand that, if my therapist is requested by me or otherwise required to communicate with a third party (e.g., with an attorney, a judge, a school, or other institution) regarding our confidential therapy, a separate "Release of Information" form will be provided and must be signed by me before any such exchange of information takes place.

* * *

I, _____, hereby acknowledge that Carolyn E Taylor, MFT, has discussed the above information with me and answered any questions I have about the nature of therapy and the therapeutic relationship. I have understood this document, and I have been provided a copy of it for my own keeping.

Client Signature(s) _____ Date _____

_____ Date _____

_____ Date _____

Carolyn E. Taylor, MFT