

Golshid Fadakar, LMFT, LPCC  
Licensed Marriage and Family Therapist, Lic. #98546  
Licensed Professional Clinical Counselor, Lic. #4459  
Telephone (949) 229-1043 • goldie@goldiefadakar.com

## **INFORMED CONSENT**

### **Introduction**

This document is intended to provide you with important information regarding the practices, policies and procedures of my office and to clarify the terms of the professional therapeutic relationship between me as the Therapist and you as the Client. Any questions or concerns regarding the contents of this document should be discussed with me prior to signing it.

### **Therapist Background and Qualifications**

I am a Licensed Marriage and Family Therapist and Licensed Professional Clinical Counselor. Both my licenses were issued and are regulated by the California Board of Behavioral Sciences. My license number is LMFT 98546 and LPCC 4459. I have worked with adolescents, adults, families, and couples. My theoretical approach is eclectic informed by and suited to the needs of individual clients.

### **Risks and Benefits of Therapy**

Psychotherapy is a process in which Therapist and Client discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Client can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Client may be experiencing. Psychotherapy is a joint effort between Client and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to Client, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of Client, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Client's perceptions and assumptions, and offer different perspectives. The issues presented by Client may result in unintended outcomes, including changes in personal relationships. Client should be aware that any decision on the status of his/her personal relationships is the responsibility of Client.

During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and

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swift at times, but may also be slow and frustrating. Client should address any concerns he/she has regarding his/her progress in therapy with Therapist.

### **Professional Consultation**

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Client.

### **Records and Record Keeping**

Therapist may take notes during session, and will also produce other notes and records regarding Client's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any client. Should Client request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Client with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Therapist will maintain Client's records for ten years following termination of therapy. However, after ten years, Client's records will be destroyed in a manner that preserves Client's confidentiality.

### **Confidentiality**

The information disclosed by Client is generally confidential and will not be released to any third party without written authorization from Client, except where required or permitted by law. There are several exceptions in which I am legally bound to take action even though that requires revealing information about a client's treatment. If at all possible, I will make every attempt to inform you when these will have to put into effect. The legal exceptions to confidentiality include, but are not limited to, to the following:

1. If there is good reason to believe you are threatening serious bodily harm to yourself or others. If I believe a client is threatening serious bodily harm to another, I may be required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens harm to him/herself or another, I may be required to seek hospitalization for the client, or to contact family members or others who can provide protection.
2. If there is good reason to suspect, or evidence of, abuse and/or neglect toward children, elderly or disabled persons. In such a situation, I am required by law to file a report with the appropriate state agency.
3. In response to a court order or where otherwise required by law.
4. To the extent necessary, to make a claim on a delinquent account via a collection agency.
5. To the extent necessary for emergency medical care to be rendered.

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### **Client Litigation**

Therapist will not voluntarily participate in any litigation, or custody dispute in which Client and another individual, or entity, are parties. Therapist has a policy of not communicating with Client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Client's legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Client, Client agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary hourly rate.

### **Psychotherapist-Client Privilege**

The information disclosed by Client, as well as any records created, is subject to the psychotherapist-Client privilege. The psychotherapist-client privilege results from the special relationship between Therapist and Client in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the client is the holder of the psychotherapist-client privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-client privilege on Client's behalf until instructed, in writing, to do otherwise by Client or Client's representative. Client should be aware that he/she might be waiving the psychotherapist-client privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Client should address any concerns he/she might have regarding the psychotherapist-client privilege with his/her attorney.

### **Fee and Fee Arrangements**

The customary fee for services is \$150 for the initial assessment and evaluation, individual session and/or conjoint (marital/family) sessions. Individual and conjoint (marital/family) sessions are 50 minutes in length. Sessions longer than 50-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Client will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payors, or by agreement with therapist.

From time-to-time, Therapist may engage in telephone contact with Client for purposes other than scheduling sessions. Client is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at Client's request and with Client's advance written authorization. Client is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes.

Clients are expected to pay at the time services are rendered. Therapist accepts cash, checks, and credit cards.

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### **Insurance**

If you wish to utilize health insurance to pay for services, I will discuss the procedures for billing your individual insurance company with you, as they vary, depending on your health insurance plan and benefits. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although I would be happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you. If for some reason you find that you are unable to continue paying for your therapy, please inform me immediately and will discuss and consider any options that may be available to you.

Patient is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payer. Therapist is not a contracted provider with any insurance company, managed care organization. Should Patient choose to use his/her insurance, Therapist will provide Patient with a statement, which Patient can submit to the third-party of his/her choice to seek reimbursement of fees already paid.

### **Cancellation Policy**

Client is responsible to provide Therapist with at least a 24-hour notice if he/she is unable to make it to his/her appointment. Client agrees to pay Therapist the full session fee for any missed appointments for which he/she did not show up and or failed to give Therapist at least a 24-hours notice of cancellation. Cancellation notice should be texted or left on Therapist's voice mail at (949) 229-1043.

### **Therapist Availability**

Therapist has a confidential voice mail system that allows Client to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

### **Therapist Communication**

I may need to communicate with you by telephone, text messaging, email, mail, or other means. Please be sure to inform me if you do not wish to be contacted at a particular time or place, or by a particular means. Text messaging and emailing are only for scheduling purposes due to confidentiality. Please do not email or text me clinical information or concerns. Any phone conversations of clinical nature exceeding 10 minutes will be charged at a pro-rated session rate. If we find that you need additional support, we may need to increase the frequency of our sessions. E-mail and text correspondence are not considered to be confidential media of communication. I am happy to further discuss any questions you may have about this policy.

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**Social Networks**

I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this reason, I request that clients not communicate with me via any interactive or social networking web sites.

**Termination of Therapy**

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Client needs are outside of Therapist’s scope of competence or practice, or Client is not making adequate progress in therapy. Client has the right to terminate therapy at his/her discretion. Upon either party’s decision to terminate therapy, Therapist will generally recommend that Client participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Client.

**Acknowledgement**

By signing below, Client acknowledges that he/she has reviewed and fully understands the terms and conditions set in this document. Client has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Client’s satisfaction. Client agrees to abide by the terms and conditions of herein and consents to participate in psychotherapy with Therapist. Moreover, Client agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

I understand that I am financially responsible to Therapist for all charges, including any other third-party payor.

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Client Name (Please print)

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Signature of Client (or authorized representative)

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Date