OFFICE POLICIES & GENERAL INFORMATION

AGREEMENT FOR PSYCHOTHERAPY SERVICES

Dr. Susan N. Thau, PhD., PsyD

Licensed Clinical Psychologist

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law.

WHEN DISCLOSURE IS REQUIRED BY LAW: Some of the circumstances where disclosure is required by law are where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, io property, or is gravely disabled.

WHEN DISCLOSURE MAY BE REQUIRED: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the defender may right to obtain the psychotherapy records and/or testimony by Dr. Thau. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Dr. Thau will use her clinical judgment when revealing such information. Dr. Thau will not release records to any outside party unless she is authorized to do so by all adult family members who were part of the treatment.

TELEPHONE & HMERGENCY PROCEDURES: If you wish to speak to Dr. Thau between session, leave a message on her voice mail (310) 829-5656. Dr. Thau checks her messages regularly unless she is out of town. If an emergency situation arises leave a message on the above numbers and then call 911.

PAYMENTS: Clients are expected to pay the agreed upon fee at the end of the session/month unless other arrangements have been made. Please advise Dr. Thau if any problem arises during the course of therapy regarding your ability to make timely payments. It is your responsibility to verify the specifics of your particular coverage (i.e. conditions that are covered, number of visits allowed and co-payment). You are responsible for the agreed upon fee irrespective of what happens with your coverage.

THE PROCESS OF THERAPY: Participation in therapy can result in several benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Psychotherapy requires your very active involvement, honesty and openness in order to change your thoughts, feelings and/or behavior. The therapy you are entering into is psychoanalytically oriented psychotherapy which includes exploring aspects of your present life situations as well as examining patterns from the past including the feelings you have about your own life experiences. You will probably have some feelings about talking to Dr. Thau and we will be discussing these as well.

CANCELLATIONS: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 36 hours notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification.

I have read the above Agreement and Office Policies and General Information carefully.

I understand them and agree to comply to them.

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Patient name (print) Date Signature

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Therapist Date Signature