Lauren Morton, LCSW
6994 El Camino Real, Suite 205-I
Carlsbad, CA 92009
Telephone: (760) 840-7508

INFORMED CONSENT AND AUTHORIZATION FOR PSYCHOTHERAPY

Welcome! This document contains important information regarding my business policies. Please read carefully and feel free to ask me any questions that you may have regarding its contents.

CONFIDENTIALITY

The law, professional ethics, and the foundation of the profession require that our therapy sessions remain confidential. Your records, information about your treatment, and the content of our sessions are protected by law and will not be released to anyone without your prior written permission. There are, however, certain exceptions to confidentiality, some of which are listed below:

- There is reasonable suspicion of past or present emotional, physical or sexual abuse or neglect of a child under the age of 18 years.
- There is reasonable suspicion of abuse, neglect, abandonment, forced isolation or fiduciary abuse of a dependent adult or any person over the age of 65.
- When a client appears to be a serious danger to self or others.
- If a valid subpoena is issued or my records are subject to a court order or other legal proceeding.
- When seeking reimbursement from insurance companies or other third parties, a psychological diagnosis must be provided for payment of services. Accordingly, clinical information may be given at the request of an insurance company to ensure payment.

Couples and Family Counseling

I implement a "no secrets" policy for clients participating in couples and family counseling. This means that I may share information that one individual reveals without the other party present during future conjoint and family sessions.

Initial here agreeing to my confidentiality policy for couples and families (if applicable):_____

Child and Adolescent Therapy

Adolescents and children in individual therapy will be afforded confidential treatment. As trust is essential to the therapeutic relationship, parents or the legal guardian(s) will be provided only with general information about how therapy with their child is progressing. No other information will be given unless I determine it to be in the youth's best interest.

Initial here agreeing to my confidentiality policy for children and adolescents (if applicable):_____

PROFESSIONAL FEES

California law requires that all fees are established and agreed upon before the commencement of therapy. This section clarifies all fees and defines your financial responsibilities.

1. My usual and customary fee is $120 per 50-55 minute psychotherapy session unless payment is covered by your health insurance or Employee Assistance Program (EAP).
2. **Fees and co-pays will be collected at the end of each session.** I accept cash, credit cards, and personal checks. A $25.00 fee will be charged for checks returned from the bank due to insufficient funds. Collection services may be used for unpaid fees.
3. In circumstances of financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. Please let me know if this applies to you.
4. Telephone conversations greater than 10 minutes per day may be billed proportional to my hourly fee.
5. Attendance at meetings, authorized telephone consultations and composition of written evaluations concerning treatment will be billed pro rata.
6. I do not provide services in contemplation of legal proceedings. If I do respond to a subpoena initiated by you or others regarding your case, I will bill you at my hourly rate.

Insurance and EAP coverage: I am a contracted provider with several insurance companies and third party payers and have agreed to a specified fee. If I am an in-network provider with your insurance company, I will process your claims directly to obtain reimbursement for services rendered. You will be responsible for any deductibles or co-payments at the end of our session. If I am not a contracted provider with your insurance plan, it is your responsibility to determine if you have any out of network benefits that may cover the cost of therapy. At your request, I can provide you with a statement that you can submit to your insurance company for full or partial reimbursement depending on your plan. It is important that you know and verify the terms of your insurance coverage because you are ultimately responsible for full payment of fees.

Cancellation and No Show Policies: Your scheduled appointment is reserved for you and only you. As a result, I require a minimum of 24 hours advanced notice to cancel your appointment without charge. Missed appointments and late cancellations (under 24 hours notice) will be charged $50 to a credit card on file. All Monday appointments must be cancelled by 5pm on the Friday before to avoid any fees. Please note that health insurance companies do not reimburse cancellation and no show fees and you are responsible for this charge.

Initial here agreeing to my cancellation and no show policy:_____

RISKS AND BENEFITS OF PSYCHOTHERAPEUTIC TREATMENT

The decision to participate in therapy is an important one offering both risks and benefits. Counseling may involve some emotional discomfort at times as difficult experiences and feelings are discussed. While this is a risk of treatment, psychotherapy has been shown to have many benefits. Therapy often leads to reduction in feelings of distress, increased satisfaction in interpersonal relationships, resolution of specific problems, and greater personal awareness and insight. Although it is my intention to provide services that will assist you in reaching your goals, I can neither guarantee resolution of a specific problem nor a particular outcome.

THERAPIST AVAILABILITY

I am often unable to be reached by phone immediately, however, I do have a confidential voicemail that allows you to leave a message at any time. I make every effort to return telephone calls within 24 hours (or by the next business day). **In the event of a crisis that requires immediate medical or psychiatric assistance, please call 911, the California Access and Crisis Line at 1-800-479-3339, or go to the nearest emergency room.** All sessions are by appointment only. I can be reached by telephone, text messaging or email to schedule, change or cancel appointments. Please note that while you are welcome to communicate issues regarding scheduling via text messaging or email, I cannot ensure the confidentiality of any form of communication through electronic media. I also request you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

TERMINATION OF TREATMENT

Ideally, therapy ends when there is mutual agreement that treatment goals have been achieved. Additional reasons for termination include, but are not limited to, non-attended sessions, untimely payment of fees, arriving to session under the influence of drugs or alcohol, failure to comply with treatment recommendations, conflicts of interest, or client needs which are outside of my scope of practice or competence. Professional ethics also mandate that treatment continue only if it is reasonably clear that you are benefiting from the services. You also have the right to refuse or discontinue services at any time. Upon either party's decision to terminate therapy, I generally recommend participation in one or more termination sessions to facilitate a positive end to the therapeutic process and to make appropriate recommendations and referrals if needed.

INFORMED CONSENT

Again, welcome! I hope that this expenditure of your time, energy and money will be worthwhile. Please sign this form verifying that you have read and understood the information in this document and agree to receive treatment in accordance with the terms and conditions detailed above. Please ask me to address any questions or concerns that you have about this information before signing. You may request a duplicate for your records.

_____ _____

Client Signature (parent/guardian for minors) Date

_____ _____

Client Signature (parent/guardian for minors) Date

_____ _____

Therapist Signature Date

☐ Client declined copy ☐ Client received copy

6994 El Camino Real ◆ Suite 205-I ◆ Carlsbad, California ◆ Phone (760) 840-7508 ◆ Fax (760) 931-9333

Lauren Morton, LCSW
3150 El Camino Real, Suite C
Carlsbad, CA 92008
Telephone: (760) 840-7508

CREDIT CARD AUTHORIZATION FORM

All clients are required to keep a valid credit card on file. For your convenience this credit card will only be used in case you miss an appointment or cancel an appointment with less than 24-hours notice ("late cancellation") or have an unpaid balance for more than 60 days. Please note cancellations for Monday appointments must be received by 5pm the Friday before. The charge for late cancellations or missed appointments is $50 .You can also elect to have your co-payments or session charges automatically billed by checking the box at the bottom of the page.

Please complete the credit card information section below. *All credit card information will be kept in a confidential and secure location.*

Credit Card Information:	
Name on Card	
Billing Address	
City, State, Zip Code	
Type of Card	☐ Visa ☐ Mastercard ☐ Discover ☐ American Express (AMEX)
Credit Card #	
Security Code	
Expiration Date	

I agree that all information provided is accurate and complete. I understand that my credit card will be charged when my session is cancelled with less than 24 hours notice or I do not attend a scheduled appointment. My credit card may also be charged if I have an unpaid balance past 60 days.

Authorized Signature: _____ Date: _____

☐ I would like to receive automatic billing. Please charge my account $_____ on the day of my appointment. *You may cancel this automatic billing authorization at any time.*

Authorized Signature: _____ Date: _____

Would you like an email confirmation of charges? Yes No
If yes, please provide email address: _____