LICIA GINNE, PsyD., MFT 21421

820 Bay Ave., Ste 205, Capitola, CA 95010
Ph: 831. 471.8647 (text or call)
www.psychotherapysantacruz.com

INFORMED CONSENT AND POLICIES FOR TREATMENT

Welcome to my practice. This document contains important information about my professional services and policies. Please read the entire document carefully and ask any questions you have regarding its contents.

Patient(s), _____, authorizes and requests therapist, LICIA GINNE, PsyD, MFT 21421, to provide psychological examinations, assessment, interventions and/or diagnostic procedures that now or during the course of treatment are advisable. The frequency and type of assessment will be decided between therapist and patient.

The purpose of these procedures and treatments will be explained and be subject to verbal agreement.

It is understood that there is an expectation that the patient will benefit from this assessment and/or interventions but there is no guarantee that this will occur.

It is understood that maximum benefit will occur with consistent attendance and that at times the patient may feel conflicted about therapy as the process can sometimes be uncomfortable. I encourage you to bring up these concerns or questions in session so we can better understand what is or is not happening for you.

CONFIDENTIALITY

All information disclosed within sessions, including that of minors, is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law. Disclosure may be required in the following circumstances:

- When there is a reasonable suspicion of abuse to a child, dependent or elder adult.
- When the client or credible third person communicates a serious threat of bodily injury to others.
- When the therapist has a reasonable belief that the client may be a danger to him or herself, others or property of others.
- When disclosure is otherwise required by law.

I receive regular professional consultation. In such cases, neither your name nor any identifying information about you is revealed.

EMERGENCY TREATMENT

If you have a life-threatening emergency, please call 911or 988. I am not able to provide 24-hour availability. I usually return calls within 24 hours or the next business day. When I am out of town or otherwise unavailable, a qualified professional will cover for me by checking my telephone voicemail.

PAYMENT

Payment is due at the end of each session unless other arrangements are made. Please notify me if any problem arises during the course of your therapy regarding your ability to make timely payment. My fee

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is $275.00 (unless we have agreed to $_____) per 50-minute session. I reserve the right to periodically adjust this fee. I will give you prior notice of fee increases.

In addition to my fee for sessions, I charge for other professional services related to your case such as report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals, preparation of records or time spent providing any other service requested by patients.

Payment can be made by check, cash, Zelle, credit card & HSA card
Zelle account DrGinne@gmail.com or phone (831) 471-8647
credit card payment can be made: https://psychotherapysantacruz.com/contact/

Fee for individual or couples is the same based on time.

50-minute session - $275.00
70-minute session - $413.00
100-minute session - $550.00

INSURANCE

I do not accept insurance. I am a private pay/cash pay business only. However, I am happy to provide you with a statement to submit to your insurance or I can submit a claim for you if you prefer. Depending on the terms of your health coverage, your plan may or may not reimburse for out-of-network services.

CANCELLED/MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with *less than 2 days*, (48) hours' notice, you will be billed according to the scheduled fee or according to the rules of the patient's health plan.

DELINQUENT ACCOUNTS

If your account becomes delinquent (past 30 days) our office may begin collection procedures. We will attempt to contact you directly. However, if your account remains delinquent we may utilize the services of an outside collection agency, we may retain an attorney, or small claims court action may be taken.

LITIGATION CHARGES

If I am required to attend a deposition, hearing or other legal proceeding in the capacity of your current or past therapist, you will be billed at $750.00 per hour for my time, including preparation and travel time as well as the time I spend at the legal proceeding. If you are a current or past client, my testimony will not include any forensic opinions.

EMAIL or TEXTING

Other than, scheduling appointments, I will not accept, review or respond to emails or texts from you or someone on your behalf. Please limit email or text communication to scheduling only. I cannot guarantee the security of texts or emails.

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TERMINATION OF THERAPY SERVICES

The length of your treatment and the timing of the eventual termination of your treatment depend on your clinical needs, the specifics of your treatment plan, and the progress you make towards achieving your treatment goals. While I hope you will find our time together beneficial and meaningful, I cannot guarantee the specific outcome(s) or result(s) your treatment will yield.

You may discontinue therapy at any time. If one of us determines you are not benefiting from treatment, we can discuss treatment alternatives. These alternatives may include, among other possibilities, changes to your treatment plan, referrals to other therapists, and/or termination of treatment. I may terminate therapy services at my discretion. I may consider termination if:

- I do not believe that I can provide you with effective treatment
- Your needs are outside the scope of my experience or training
- You desire to terminate treatment or we mutually agree it is time to terminate treatment
- You fail to comply with my treatment recommendations
- A conflict of interest develops
- You fail to pay my fee on a timely basis
- You or I believe it is in your best interest

ADDRESS CHANGES

Please advise me if you change your address, telephone number, place of employment or insurance coverage or companies.

Please let me know if you have any questions or concerns regarding my policies.

ACKNOWLEDGEMENT AND AGREEMENT FOR INFORMED CONSENT

I have read and fully understand this Consent for Treatment form.

Client Name Client Signature **Date**

Client Name Client Signature Date