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**Informed Consent**

This informed consent form is intended to answer many of your questions about the mental health services I offer. Please feel free to ask for clarification or additional information.

**Introduction**: Mental health services are not easily described in general statements, as the nature of the work varies depending upon the issues being presented. Also, it is important to tailor the approach and the goals for treatment to your individual needs. To receive benefit from these services, active effort is often required both during and in between sessions.

**Confidentiality**: By law and professional ethics, your sessions are considered confidential. Generally, no information will be shared with anyone without your written permission. It may be necessary for me to contact other health providers, so that we can coordinate our efforts, but I will not do so without first asking for your permission. However, there are a number of exceptions to this confidentiality policy. The exceptions to confidentiality are:

* If you are a victim or perpetrator of child abuse I am required by law to report this to Child Protective Services (CPS) or other appropriate authorities.
* If you are a victim or perpetrator of elder or dependent adult abuse I am required by law to report this to Adult Protective Services (APS) or other appropriate authorities.
* If you threaten harm to yourself, someone else, or the property of others, I may be required to inform the police, warn potential victims, or take other reasonable steps.
* If I am ordered by the court to testify or release records.

**Fees**: My fee is $200.00 per hour unless otherwise agreed upon. Payment is expected by cash or personal check at the completion of each session. I do not provide monthly billing. Fees may be increased on a yearly basis, but only with reasonable notice.

**Insurance**: I do not accept insurance. If you would like to submit a bill to your insurance company, I am willing to provide you an itemized statement at the end of each month. You should be aware that if you decide to utilize your insurance benefits for psychotherapy services, you may not have the extent of confidentiality you would otherwise expect.

**Late Cancellations**: You will be charged full fee for missed or cancelled sessions unless I am given 24 hours notice.

**After Hours Emergencies**: I am not available after hours for emergencies. I regularly check messages on weekdays from 8:00 AM to 6:00 PM and will generally return calls the same business day. If you experience an after hours psychiatric emergency, you should go to the emergency room in your area or call 911.

**Vacations**: I will give you reasonable notice prior to taking vacations. For extended vacations, I will arrange to have a colleague cover my practice for urgent matters.

**Risks and Benefits**: There are potential risks and benefits to psychological services. Sessions often involve discussing unpleasant aspects of your life, which may lead to you to experience uncomfortable feelings. These services have been shown to have benefit, but there are no guarantees of what you will gain.

**Terminating Treatment**: You have the right to terminate services at any time. However, if you decide to do so, I would ask that you discuss your decision with me so that we can bring sufficient closure to our work together.

**Signature**: Signing this form indicates that you have read, understand, and agree to the information and policies described above.

Print Name

Signature

Date