# Informed Consent and Disclosure Statement & Agreement for Services

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me, your therapist, any questions that you may have regarding its contents.

Information  About YourTherapist

Lesa Pascali Marriage and Family Therapist
LMFT 47946
Phone Number-408-660-6038

Fees and Insurance

The fee for service is $_____ per therapy session and sessions are approximately 50 minutes in length.

Please pay for your therapy session at the before the beginning of each session before therapy starts. You can pay me through Zelle.  I will send you a link before our appointment so the transaction can be completed.

All sessions at this time will be conducted via telehealth during the COVID-19 pandemic.  I will send you a Zoom link so we can connect for your appointment.

I am not taking insurance at this time.

.Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible (unless we have made a prior arrangement). I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hours in advance of your appointment. If you do not provide me with at least 24 hours' notice in advance, you are responsible for payment for the missed session.

Therapist Availability/Emergencies

You are welcome to phone me in between sessions. However, as a general rule, it is my belief that important issues are better addressed within regularly

scheduled sessions. You may leave a message for me at any time on my confidential voicemail. If you wish for me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during my normal workdays within 24 hours. If you have an urgent need to speak with me please indicate that fact in your message to my voice mail. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance. Please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. If you have an urgent need to speak with me please indicate that fact in your message. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Therapist Communications

I may need to communicate with you by telephone or other means. Please indicate your preference by checking one of the choices listed below. 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

☐ My therapist may call me on my home phone. My home phone number is:
( ) _____

☐ My therapist may call me on my cell phone. My cell phone number is:
( ) _____

☐ My therapist may send a text message to my cell phone. My cell phone number is: ( ) _____

☐ My therapist may call me at work.
My work phone number is: ( ) _____

☐ My therapist may communicate with me by e-mail. My e-mail address is:_____

Disclosure statement regarding policies and procedures for using e-mail or text message can help patients understand and acknowledge certain limitations and risks that accompany electronic communications. Sensitive, clinical information is to be discussed over the phone or in-person as deemed appropriate me. For appropriate-mail or text communication therapist will respond to your e-mail or

text within 24 hours. Potential risks of using electronic communication may include, but are not limited to; inadvertent sending of an e-mail or text containing confidential information to the wrong recipient, theft or loss of the computer, laptop or mobile device storing confidential information, and interception by an unauthorized third party through an unsecured network-mail messages may contain viruses or other defects and it is your responsibility to ensure that it is virus-free. In addition-mail or text communication may become part of the clinical record. You may be charged for time I spend reading and responding e-mail or text messages.

About the Therapy Process

It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion. I will work with you to develop an effective treatment plan. Over the course of therapy, I will attempt to evaluate whether the therapy provided is beneficial to you. Your feedback and input is an important part of this process. It is my goal to assist you in effectively addressing your problems and concerns. However, due to the varying nature and severity of problems and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

Confidentiality

All communications between you and I will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, I will not disclose information communicated privately to him or her by one family member, to any other family member without written permission.) T here are exceptions to confidentiality. For example, therapists are required to report instances of suspected child, dependent adult or elder abuse. Therapists may also be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. However, it is important that you know that I utilize a “no-secrets” policy when conducting family or marital/couples therapy. This means that if you participate in family, and/or marital/couples

therapy, I am permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family. Please feel free to ask me about my “no secrets policy” and how it may apply to you.

Minors and Confidentiality

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child’s treatment are often involved in their treatment. Consequently, I, in the exercise of my professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with me.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. I will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or I, as your therapist, determine that you are not benefiting from treatment, either of you or I may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy. Your signature indicates that you have read this agreement for services carefully and understand its contents. Please ask me to address any questions or concerns that you have about this information before you sign.

Name of Patient(s)_____

Signature(s)_____

Date_____