San Diego Therapy Care

Dr. Denise Grundland, Licensed Psychologist, PSY30302
Phone 858-876-7427 | www.SanDiegoTherapyCare.com

Informed Consent & Therapeutic Contract

This document contains important information about what to expect from therapy, from me (your therapist), and what I will expect from you in order to be most helpful. Please read it carefully and feel free to bring questions to me. By signing this document, it represents an agreement between us and that you have fully understood it.

Psychological Services

The therapeutic relationship is unique in that it is both a highly personal one and at the same time it is a professional one governed by a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work best. The success of therapy is highly dependent on the trust built between the client and the therapist. Feedback is paramount to the process by letting me know what you are thinking about treatment and where it is headed. It is important to remember that I can only help you with what you are willing to share, so openness is key, but only once you are comfortable. You are empowered to control the pace of therapy.

Psychotherapy is a process of meeting weekly with a trained mental health professional to help understand your concerns more clearly and work towards accomplishing your goals. You will learn valuable tools and techniques to help you learn more about yourself, better understand your personal values, work through or disentangle a problem, improve how you relate to others, and gain greater self-confidence, self-respect, and self-acceptance. Your first few sessions will involve my evaluation of your unique needs during which I will offer you some initial impressions of how our work together could be helpful. There are many empirically supported interventions that I utilize to address the symptoms you are experiencing. **Psychotherapy is not like a medical doctor visit in that there are no quick fixes. Instead, it requires a very active effort and focus on your part, a whole lot of teamwork, and treatment planning on my part done with a trained eye.** The extent to which you are open and honest with me will play a role in how effectively we can work toward achieving your goals. Now that you know what psychotherapy does includes it is important for you to note that professional therapy never includes sexual relations between a therapist and a client.

Psychotherapy can have benefits and risks. Just as therapy may provide you with welcomed relief and exciting insights, at times, therapy may cause considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, sadness, depression, anxiety, etc. These are usually temporary releases of emotion that have been held in which we will process together. However, I cannot guarantee that your behavior or circumstance will change through therapy. What I can do is promise to support you and do my very best to understand you and the complexities of your issue. I can help you clarify what it is that you want and be able to help you see your strengths by the end of therapy. Making changes in your thinking or behaviors can be scary and sometimes disruptive. On the other hand, clients find that their relationship with their therapist and the work done in psychotherapy results in benefits such as improved relationships, solutions to specific problems and significant reductions in feelings of distress. Most people who invest in therapy find that it is helpful and feel that they have benefited by the end.

Meetings & Professional Fees

Sessions are 50 minutes in length and are held once per week. As treatment continues, we might agree to taper off and meet less frequently as you progress and get closer to graduation/termination. Unless I am networked with your insurance (Cigna or Aetna), my fee per session is $150 or a lower fee if for some exception, I have pre-approved another rate and we have both initialed here: ($___|___|___). **If you have a 75-minute session your fee will have an additional $70 billed to account for the extra time.**

Cancellation Policy & Late Appointments

I have a 24-hour cancelation policy, which requires you to call and reschedule or cancel prior to **24 hours** before your scheduled appointment time or you will be charged the full fee and will be considered a "Late Cancel". Insurances do not reimburse me for client's missed or canceled appointments thus your credit/debit card on file will be charged $150. If you accrue multiple Late Cancels this will prompt a conversation between you and I to explore what is going on and if this is the right time for therapy. At my sole discretion, I may waive the late cancellation fee for good cause. Any waiver shall not be considered a waiver for future occurrence. If you are more than **15 minutes late** to any appointment and have not made contact, the session will be considered a **"No Show"** and I reserve the right to take a work break during that time and refuse to start a session that late. **You will be charged for the full session fee.** If you have two "No Shows" we will discuss possible termination of therapy for failure to show a commitment to your own personal growth and we can resume when you are more committed to attend consistently. **If you have not been seen for one month and do not have an appointment scheduled you will no longer be considered an active client. It is recommended that patients show up 2-3 minutes early to session and use the restroom so that they are comfortable and mentally present during the session. Most of my patients are no more than 5 minutes late to our sessions.**

Credit Card Information

A current credit card number of the financially responsible person must always be on file. Your credit card will only be used to pay for missed appointments, late cancellations, and unpaid balances, unless other arrangements are made. Payment by cash, credit card, or check is due at the time of your appointment.

The credit card to remain on file is:

Please circle one: MasterCard or Visa or _____

Name as it appears on the card: _____
Credit Card Number: _____
Expiration Date: _____ Security Code: _____

Billing Address: Street: _____
City: _____ State: _____ Zip: _____

I authorize Denise Grundland, Psy.D., with San Diego Therapy Care, to charge my credit/debit card for any missed appointment fees, late cancellation fees, and/or unpaid balances. I understand that I am responsible for all charges.

Signature of cardholder: _____ Date _____

Professional Records

The laws and standards of the profession require that this practice keep treatment records. You are entitled to receive a copy of your records or, instead, I can prepare a summary for you. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, it is recommended that we review them together so that the contents can be discussed. Clients will be charged an appropriate fee for the professional time spent in responding to information/copy requests.

Confidentiality, Privacy, & Secure Communication

What we talk about in session, or the session content, and all relevant materials for your treatment such as your patient file will be held confidential and stay between us unless you request in writing to have all or portions of such content released to a specifically named person/persons. According to the law, however, there are limitations and exceptions to your held privilege of confidentiality that exist and they are listed below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named person is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years. This includes the watching, downloading, or partaking in child pornography/minor focused pornography.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses, including financial abuse.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If I am asked to speak with emergency personnel in order to coordinate life saving or stabilizing care for you.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.
Also, if we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but I will feel it appropriate not to engage in any lengthy discussions in public or outside of therapy. **I will also not accept any invitations to connect on social media** for the purposes of protecting your privacy and to maintain a professional boundary that is needed for therapy to be truly effective. I will not respond to text messages. Please use email only for scheduling or changing appointments and other administrative means, as it is not a secure way for us to communicate about important things. You can always leave me a confidential voicemail and I will strive to call clients back between 1-2 business days.

Emergency Procedure

If you are experiencing a life-threatening emergency, such as suicidal thoughts or a medical emergency, please call 911 or go to your nearest emergency room. If you are experiencing a mental health crisis you can contact the Access and Crisis Line at 888-724-7240 (counselors are available 24 hours a day, 7 days a week).

Client Litigation

I will not voluntarily participate in any litigation, or custody dispute in which you and another individual, or entity, are parties. I will generally not provide records or testimony unless compelled to do so by the courts. Should I be subpoenaed or ordered by a court of law to appear as a witness, the fee for any time spent for preparation, travel, or other time in which I am available for such an appearance is $350 per hour. Time spent in court or being deposed will be billed at $400 per hour.

Client Rights

You have the right to ask questions about anything that happens in therapy. I am always willing to discuss how and why I decided to do what I am doing in session, and to consider alternatives that may work better. You can request that I try something else you think may be more helpful. You can request information about my training in working with your particular problem; you can always choose to see another therapist instead of me or get a

second opinion. You are free to end therapy at any time and can decline services altogether. Termination is an important step of therapy and usually looks like one or two sessions dedicated to reviewing all of your growth and strengths and, when appropriate, reviewing further treatment recommendations and referrals. If you are ever unhappy or dissatisfied with my services I ask that you please come to me and tell me that you have constructive feedback as I too need these opportunities to grow as a psychologist and as a person. I welcome your feedback. I am here to help.

Responsibilities of a Therapy Client

1. Clients are responsible for coming to their appointment on time, as scheduled. If clients are late, the session will end on time and not run into the next client's appointment time.
2. Clients who are using insurance are responsible for paying their copayment at each appointment.
3. The client is responsible for informing their clinician of any change in insurance coverage, address and phone number and emergency contacts.
4. The client is responsible for putting forth around 50% of the effort in the therapeutic work.

Consent to Psychotherapy

I/we have read this statement, had sufficient time to be sure that I/we considered it carefully, and understand it. I/we consent to the use of a diagnosis in billing (if applicable), and to release that information and other information necessary to complete the billing process (if applicable). I/we understand receiving assessment and/or treatment with my clinician as described above. I/we know that I/we can end therapy at any time, and that I/we can refuse any requests or suggestions made by my clinician. I/we agree to abide by the terms of this contract and that I/we understand it in its entirety.

Printed Name of Partner 1 _____

Signed:(Client)_____ Date_____

Printed Name of Partner 2_____

Signed:(Client)_____ Date_____

Clinician Name_____

Signed (Clinician): _____ Date_____

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PARTNER ONE INTAKE HISTORY

Patient Name:_____ Birth date: ____/____/_____
Phone number:_____ Address:_____
Social Sec. #: _____ Ethnicity: _____ Religion/Spirituality:_____
Gender: _____ Sexual Orientation:_____ Height_____Weight:_____
Marital Status:_____ Quality of relationship?_____
People living in your household and relationship:
_____
_____

Name of person completing form (if other than patient):_____
Relationship to patient:_____
Name of Guardian (if applicable): _____
*Name of in case of Emergency Contact:_____
Relationship to client:_____ Phone #:_____
How you heard about me: Insurance Friend My Website Referral Other: _____

Primary Care Physician: _____
Approximate Date of Last Physical Exam or visit: _____
Current *Medical* Condition(s), if any:
_____
_____

What caused you to get help now and come to therapy?
_____
_____
_____

Any pregnancy or developmental abnormalities that you experienced as a baby in your Mother's womb? No___ Yes___ (Please explain)
_____

Any issues with your birth? (Example, umbilical chord wrapped around neck) If so what happened:_____

Did you ever have a major hit to the head/fall on your head/get knocked unconscious?
If so what happened:
_____
_____

What is the highest level of education you have finished: _____
Was school easy, average, or hard for you and how/why?_____
If you are employed *what do you do* and *who is your employer*:
_____ _____

Are you currently taking any prescription or "over the counter" medication(s)?
No___ Yes___If Yes, please identify the name, current dosage, their purpose, and for how long taken:
_____

Do you have any allergies? No___ Yes___ If yes, please list:_____
_____
Have you ever been in psychotherapy of any kind before? No___ Yes___
What did you work on?_____
Please list the total estimated months/years of outpatient treatment you have had:_____ What was your age at the first visit? _____ Was this experience: Good___ or Bad____

Have you ever been hospitalized or stayed in a psychiatric hospital for reasons of mental health or substance abuse? No___ Yes___
If Yes, please list facility(ies) date(s) and length(s) of stay(s) & what your condition was:
_____

Do you smoke cigarettes? No___ Yes___ If yes, how many per day? _____
How much alcohol do you drink per week on average? _____ drinks per week
Have you had problems with your drinking (legal, health, work, relationship?)
No___ Yes___ If Yes, please explain:
_____
_____
Do you use marijuana? No__ Yes___ If so, how often? _____
Recreationally/For Fun or for a medical/emotional condition?_____

Have you ever been arrested or convicted of a crime? No__ Yes__ If yes, please describe:_____
Are you currently involved in a lawsuit? No___ Yes___ If yes, please describe:_____
Please answer whether or not you are experiencing any of the following symptoms:

Appetite Problems ..... N____ Y____
Sleep Problems ..... N____ Y____
Physical Complaints ..... N____ Y____
Anger/Irritability ..... N____ Y____
Isolation/Social Withdrawal ..... N____ Y____
Anxiety/Panic ..... N____ Y____
Phobia ..... N____ Y____
Bingeing/Purging ..... N____ Y____
Poor Impulse Control ..... N____ Y____
Violence Toward Others ..... N____ Y____
Destruction of Property ..... N____ Y____
Strange or Unusual Behavior ..... N____ Y____
Confused or Irrational Thinking ..... N____ Y____
Bothersome Repetitive Thoughts or Behaviors N____ Y____
Self-mutilation ..... N____ Y____
Suicidal Thoughts/Impulses ..... N____ Y____
Homicidal Thoughts/Impulses ..... N____ Y____

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PARTNER TWO INTAKE HISTORY

Patient Name:_____ Birth date: ____/____/_____
Phone number:_____ Address:_____
Social Sec. #: _____ Ethnicity: _____ Religion/Spirituality:_____
Gender: _____ Sexual Orientation:_____ Height_____Weight:_____
Marital Status:_____ Quality of relationship?_____
People living in your household and relationship:
_____
_____

Name of person completing form (if other than patient):_____
Relationship to patient:_____
Name of Guardian (if applicable): _____
*Name of in case of Emergency Contact:_____
Relationship to client:_____ Phone #:_____
How you heard about me: Insurance Friend My Website Referral Other: _____

Primary Care Physician: _____
Approximate Date of Last Physical Exam or visit: _____
Current *Medical* Condition(s), if any:
_____
_____

What caused you to get help now and come to therapy?
_____
_____
_____

Any pregnancy or developmental abnormalities that you experienced as a baby in your Mother's womb? No___ Yes___ (Please explain)
_____

Any issues with your birth? (Example, umbilical chord wrapped around neck) If so what happened:_____

Did you ever have a major hit to the head/fall on your head/get knocked unconscious?
If so what happened:
_____
_____

What is the highest level of education you have finished: _____
Was school easy, average, or hard for you and how/why?_____
If you are employed *what do you do* and *who is your employer*:
_____ _____

Are you currently taking any prescription or "over the counter" medication(s)?
No___ Yes___If Yes, please identify the name, current dosage, their purpose, and for how long taken:
_____

Do you have any allergies? No___ Yes___ If yes, please list:_____
_____
Have you ever been in psychotherapy of any kind before? No___ Yes___
What did you work on?_____
Please list the total estimated months/years of outpatient treatment you have had:_____ What was your age at the first visit? _____ Was this experience: Good___ or Bad____

Have you ever been hospitalized or stayed in a psychiatric hospital for reasons of mental health or substance abuse? No___ Yes___
If Yes, please list facility(ies) date(s) and length(s) of stay(s) & what your condition was:
_____

Do you smoke cigarettes? No___ Yes___ If yes, how many per day? _____
How much alcohol do you drink per week on average? _____ drinks per week
Have you had problems with your drinking (legal, health, work, relationship?)
No___ Yes___ If Yes, please explain:
_____
_____
Do you use marijuana? No__ Yes___ If so, how often? _____
Recreationally/For Fun or for a medical/emotional condition?_____

Have you ever been arrested or convicted of a crime? No__ Yes__ If yes, please describe:_____
Are you currently involved in a lawsuit? No___ Yes___ If yes, please describe:_____

Please answer whether or not you are experiencing any of the following symptoms:

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Destruction of Property ..... N____ Y____
Strange or Unusual Behavior ..... N____ Y____
Confused or Irrational Thinking ..... N____ Y____
Bothersome Repetitive Thoughts or Behaviors N____ Y____
Self-mutilation ..... N____ Y____
Suicidal Thoughts/Impulses ..... N____ Y____
Homicidal Thoughts/Impulses ..... N____ Y____