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INFORMED CONSENT

**Introduction**

The therapeutic relationship is a unique and highly personal relationship as well as a privileged agreement. This document is intended to provide important information for our work together. Please read carefully and discuss any questions with me. Your signature indicates that you have reviewed and agreed to the information included in this document.

**Information about the therapist: Angela Luna, LMFT**

I am a psychotherapist, educator and trainer with over 9 years of experience working with children, individuals and organizations. I enjoy working with clients from diverse cultural, linguistic, and socioeconomic backgrounds, providing psychotherapy services in English and Spanish. I specialize in working with clients who have experienced traumatic experiences in their life, including childhood abuse, sexual abuse, sexual assault and domestic violence. I also enjoy offering trainings for psychotherapists, organizations, hospitals, educators, law enforcement, clergy and non-profits on Trauma/PTSD, Expressive Arts Therapy, Animal Assisted Therapy and Mindfulness.

I incorporate trauma informed Cognitive Behavioral Therapy, EMDR, Expressive Arts Therapy and Mindfulness (which includes visual art, music, movement, play and integrative mind body interventions) in my work. I find the power of the creative process open doors for clients in the most powerful ways. Clients tell me that they get comfort from my empathic attunement, proactive approach and willingness to challenge them to move through painful feelings and life circumstances. I was humbled to hear, “I asked you for a flower, you gave a garden.” I aspire to continue to grow gardens with all I encounter.

**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, I will provide recommendations and we will co-create goals for your treatment. We will re-visit your goals and adapt them according to your progress and needs. Due to the varying nature and severity of problems and the individuality of each patient, I am unable to predict the length of yours therapy or to guarantee a specific outcome or result.

**Fees and Insurance**

The fee for service is:

$160 per 50 minute individual therapy session.

$225 per 80 minute individual therapy session.

$ 375 per 3 hour therapy deep dive session.

Phone sessions and emergency contacts 10 minutes and over are billed at the same rate as 50 minute session.

Fees are reviewed annually. If my fees change at any point in the future, I will provide 60 days’ notice of any changes. If for some reason you find that you are unable to continue paying for your therapy, you should inform me. I will help you to consider any options that may be available to you at that time.

As part of my policies I keep a credit card on file in my secure online system for all clients. By signing this informed consent you agree to keep a current credit card on file and agree to be charged for your sessions and any late cancellations or no show appointments.

While I do not bill insurance, I can provide you with an invoice of services to provide to your insurance company. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. I am unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns with me and/or your insurance provider. You may consider asking your insurance provider the following;

* If mental health benefits are provided.
* How many sessions are covered per year.
* How much is covered per session.
* If approval required from primary care physician.

**Appointment Scheduling and Cancellation Policies**

Sessions are typically scheduled to occur one time per week at the same time and day. We may discuss a different schedule 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 me at least 48 hrs. in advance of your appointment. If you do not provide me with at least 48 hour notice in advance, you are responsible for the full payment for the missed session.

**Therapist Availability/Emergencies**

Telephone consultations between office visits are welcome, though I will attempt to keep those contacts brief as important issues are better addressed within regularly scheduled sessions. Nonurgent phone calls are returned during normal workdays (Monday - Friday) within 48-72 hours. I am generally not available to return calls on weekends or after 8 pm. If you have an urgent need to speak with me, please indicate that fact in your message and follow any instructions that are provided by my voicemail. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance. You may access the following resources in the local community to assist individuals who are in crisis:

* Crisis Support Services of Alameda County: 1-800-273-8255
* [Contra Costa Crisis Center](http://www.crisis-center.org/): 24-hour Access Line: 1-888-678-7277
* [Contra Costa Crisis Center](http://www.crisis-center.org/): 800-833-2900

**Termination of Therapy**

You may discontinue therapy at any time. The length of your treatment and the timing of the eventual completion of your treatment depends on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination/completion of therapy, in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals. If you or I determine that you are not benefiting from treatment, either you or I may elect to initiate a discussion of your treatment alternatives.

**Confidentiality**

The session content and all relevant materials to the client’s treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/ persons. Limitations of such client held privilege of confidentiality exist and are itemized 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 victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
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 a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert’s report to an attorney.

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.

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.

**Minors and Confidentiality**

Communications between therapists and minor patients (under the age of 18) are confidential. Parents and guardians who provide authorization for their child’s treatment are often involved in the treatment. I will exercise professional judgment in discussing the treatment progress of a minor patient with parent or guardian.

**Record Keeping**

Your records are maintained and stored in a secure, HIPAA compliant system. Please ask any questions or concerns you have regarding record keeping. As with any record keeping method, every foreseeable precaution has been taken to protect privacy, but there are no guarantees.

**Therapist Communications**

Your therapist may need to communicate with you by telephone, mail, text or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time, place, or means.

My therapist may call me at my home. Y / N Message Ok?

My therapist may call me on my cell phone. Y / N Message Ok?

My therapist may send mail to me at my home address. Y / N

My therapist may communicate with me via text. Y / N

My therapist may communicate with me by email. Y / N

I understand that e-mail and texts are not a completely private form of communication. Y / N

**Emergency Contact**

In case of emergency, I prefer my therapist contact ( name/relationship) at this number

Your signature indicates that you have read all proceeding pages of this agreement for services carefully and understand its contents. Please ask your therapist to address any questions or concerns that you have about this information before you sign! Please note typing your full name first, middle, and last and the date constitute a legal signature for the purposes of this form. You always have the option of printing this form and bringing it to your first appointment.

Name: Date:

Signature: