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INFORMED CONSENT

Welcome to my practice. This document contains important information about my professional services and business policies and how they may affect you. Please read it carefully and make note of any questions you want to discuss with me. Once you sign this document, it will become a binding agreement between us and also provide your consent for us to begin therapy.

Therapy is a unique and highly individual experience with the outcome determined by the effort and motivation you bring to work towards a change in yourself and how you see the world around you. It can result in a number of benefits to you and can potentially help in your ability to detect, challenge, and change beliefs and attitudes that create, maintain, and worsen feelings of depression, anxiety, panic, anger, frustration, etc. Therapy also has the potential to help you gain new or deeper understanding about your issues and learn new ways of coping with and solving them.

However, there is no guarantee that therapy will yield positive or intended results. Because feelings will be explored, you may feel a range of emotions that can be intense and uncomfortable at times. During the course of therapy, some of your assumptions, perceptions, or behaviors may be challenged, which can cause you to feel very upset, angry, depressed, uncomfortable, confused, or disappointed. I encourage you to explore those feelings during our sessions, as they are part of the therapeutic process. In the attempt to resolve issues that originally brought you to therapy, unintended changes in your personal and interpersonal relationships may result.

Our therapeutic relationship is strictly voluntary. At any time during our work together, you have the right to decide to end treatment. If you are thinking about ending therapy, I encourage you to discuss it with me, and if you wish, I will be glad to provide you with the names of other mental health providers. During the course of therapy, if I assess that I am either unable or not effective in helping you reach your therapeutic goals, I will discuss this with you, and if appropriate, terminate treatment. I will provide you with appropriate referrals and assist you in the transition to a new therapist if you so desire.

Meetings

Each session lasts 50 minutes and will begin at the time agreed with you. Typically, therapy sessions take place on a weekly basis, at a mutually agreed time.

Cancellations and Rescheduling

If you need to cancel or reschedule a meeting, please notify me at least 24 hours in advance of our scheduled meeting or you will be responsible for full payment for the session. Keep in mind that insurance companies do not reimburse you for a missed session or a late cancellation.

Fees and Insurance

Your session fee is \$ _____. Payment of this fee needs to be made at the end of each session in full unless other arrangements have been made. This fee may be re-negotiated during the course of therapy. In the event of any fee changes, you will be notified at least 30 days prior to such changes.

I do not take insurance, but I can provide you with a superbill for you to submit to your insurance company. If you wish to seek reimbursement for my services from your health insurance company, please contact your insurance company to find out their limits of coverage for mental health services. Once you have done so, I will submit a superbill to the insurance company. Insurance companies vary greatly in their coverage of psychotherapy services, so check your policy to make sure that services provided by a licensed Marriage & Family Therapist are covered. You will also want to determine limits of reimbursement and deductibles. If carrier requires a diagnostic code, I will discuss my diagnosis with you before I submit this information.

Additional Fees

Extended sessions and telephone conversations that exceed 15 minutes will be charged a fee based on your regular session fee. Written reports, evaluations, and review of documents authorized or requested by you, or copying of your file follow this same policy.

Contacting me

You may contact me at 323-528-6747, either by phone or text, or email me at vgilbertmft@gmail.com any time. I will try my best to respond within 24 hours. On holidays and on vacation, I will only respond in case of emergency, otherwise I will respond on Monday or the day after the holiday. Phone calls are generally limited to 15 minutes, beyond this time you will be charged at a prorated amount of my usual fee.

Email Usage

By nature, therapy is confidential. You can have the confidence that your insights, vulnerable experiences, and feelings will not be repeated outside the therapeutic relationship established. By nature, email correspondence is NOT confidential. Though Internet security measures can be effective, it is never 100% seal proof. My policy regarding email usage is as follows: Email correspondence with me is NOT secure. Email correspondence is NOT a substitute for person-to-person therapeutic treatment, unless discussed with me in advance and in person. Email correspondence is NOT to be used in the case of an emergency to contact me. If you need to contact me with something that demands immediate attention, you will do so by voicemail at the following number: 323-528-6747, call 911, or go to the emergency room. If it becomes necessary, I will terminate treatment if email usage is or becomes inappropriate.

Emergencies

If you are experiencing a life-threatening emergency and need to talk to someone immediately, you can call 911, the Suicide Prevention Hotline at (800) 273-TALK (8255), the police, or your local hospital emergency room and ask for the psychologist or psychiatrist on call.

Confidentiality

Everything you say and share in session is strictly confidential. However, there are some exceptions to the rule of confidentiality. I am required by law to report:

- threats of harm to self or other
- suspected child or elder abuse (past or present)
- by court order

Other exceptions include:

- per your signed release
- I may discuss your case with peer counselors, in order to provide excellence in the service I give and in accordance with accepted professional behavior. In doing so, I will keep your identity or any details allowing your identification confidential.

When working with minors, confidentiality will be kept unless there is a concern that the child is in danger to themselves, someone else, or has been harmed. In these cases the parent(s) will be notified of the concern and if possibly, I will have discussed the matter with the minor and have done my best to handle any objections he/she may have. During treatment, I will provided parents with only general information about the progress of treatment and the attendance of scheduled sessions.

Agreement

I have read this information fully and completely, I have discussed any questions I had about the information, and I understand the information. I acknowledge that it is my choice to participate in psychotherapy (or have my child participate). I realize that the outcome of therapy depends upon my personal investment in the therapy process. I have familiarized myself with the fees and charges for services provided Virginia Gilbert, M.A., L.M.F.T., and I understand and agree that the therapeutic services rendered will be charged to me and not to any third-party payer. I acknowledge responsibility for payment of these services.

Signature of Patient

Date: ___/___/___

Signature of Parent/Guardian

Date: ___/___/___