Robyn Coughlin, LCSW
8690 Aero Drive
STE: 115-219
San Diego, CA 92123

INFORMED CONSENT

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is my desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: I provide short-term counseling designed to address many of the issues my clients are dealing with. Your first visit will be an assessment session in which we will determine your concerns, and if both agree that I can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you, services to you may be terminated.

My goal is to provide the most effective therapeutic experience available to you. If at any time you feel that you and I are not a good fit, please discuss this matter with me immediately so we can determine if transferring to a more suitable Therapist is right for you. If we decide that other services would be more appropriate, I will assist you in finding a provider to meet your needs.

APPOINTMENTS: Appointments are typically scheduled on a weekly or biweekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate. If you must cancel or reschedule your appointment, please email or call 619-997-5310 as soon as possible. Please know, if you have not provided a notification at least 24 hours in advance of your cancellation, you will be required to pay the full cost of the missed individual session prior to your next appointment.

FEE SCHEDULE:	Diagnostic & Evaluation Session (1st visit)	$__170____
	Regular Office Visits (50 minutes) (Individual Therapy)	$__170____
	Outside Office Work (inpatient visits, court, consultation)	$__170/hr__
	Returned check fee per check	$__25____
	No show/ Late cancellation fee	$__170___

A reasonable fee will be charged for copies of any records requested by the Client.

PAYMENT/INSURANCE FILING: Payment of fees is expected at the time of each appointment. I request that payment be made before your session begins. If you do not cancel your scheduled appointment within a 24 hour period, full payment of services will be expected within one week of the appointment. Any appointment extended over the pre-arranged agreed amount of time will be charged $20 for every 15 minutes. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, I expect full payment at the time of service, and I will provide you with a statement for services rendered. Monthly payment arrangements are available if needed for clients who have established a payment record for three months.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact my office regarding the nature and urgency of the circumstances. I will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, I will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours or on a weekend, I request that you contact The **Crisis Line at 1-888-724-7240**. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help.

CONFIDENTIALITY: As a Licensed Clinical Social Worker I follow all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.
Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my Robyn Coughlin, LCSW believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to Robyn Coughlin, LCSW to contact the any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to Robyn Coughlin, LCSW to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name _____ Telephone Number _____

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Robyn Coughlin, LCSW will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order. Lastly, I understand that if I cancel more than three consecutive sessions, services will be re-evaluated, and referrals to other providers will be provided.

_____ _____
Signature – Client/Parent Date

_____ _____
Signature – Spouse/Partner/Parent Date

_____ _____
Therapist Date