**AGREEMENT FOR SERVICES / INFORMED CONSENT**

**Introduction:**

This agreement is intended to provide (name of patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (herein “Patient”) with important information regarding the practices, policies and procedures of Dr. Fowler, and to clarify the terms of the professional therapeutic relationship between Dr. Fowler and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Dr. Fowler prior to signing.

**Dr. Fowler Background and Qualifications:**

Dr. Fowler holds a Doctorate in Clinical Psychology, a Master of Arts Degree in Psychology and a Master of Science in Marriage and Family Therapy. Dr. Fowler is licensed in the State of Washington as a Clinical Psychologist (Lic# PY61031943).

Dr. Fowler has worked in a variety of settings, including conducting neuropsychological assessments for individuals with acquired brain injuries and neurodegenerative conditions, working in school systems (elementary through college), community counseling centers, non-profit organizations, foster care systems, inpatient drug & alcohol treatment centers, and for the department of mental health. Dr. Fowler trained most recently at the UCLA Semel Institute for Neuroscience and Human Behavior and Cedars-Sinai Medical Center, and the Department of Psychiatry at Kaiser Permanente Medical Center.

**Risks and Benefits of Therapy**:

Psychotherapy is a process during which time we will discuss many issues, events, experiences, and memories for the purpose of creating positive change. Participating in therapy may result in a number of benefits including reduced stress and anxiety, a decrease in negative thoughts, improved interpersonal relationships and increased self-confidence. Such benefits may require substantial effort, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts, and behaviors.

Participating in therapy may also involve some discomfort; including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, or guilt. The issues presented in psychotherapy may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationship is the responsibly of the Patient.

During the therapeutic process, sometimes Patient finds he/she occasionally feels worse before he/she feels better. This is generally a normal course of events. Personal growth and change maybe easy and swift at times, but may also be slow and frustrating. Patient should address any concerns he/she has regarding his/her progress in therapy with Dr. Fowler.

**Professional Consultation**:

Professional consultation is an important component of a healthy psychotherapy practice. As such, Dr. Fowler regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Dr. Fowler will not reveal any personally identifying information regarding the Patient.

**Confidentiality**:

The information disclosed in psychotherapy is generally confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law. Exceptions to

confidentiality include, but are not limited to: reporting child, elder and dependent adult abuse, when Patient

makes a serious threat of violence toward a reasonably identifiable victim, or when Patient is dangerous to him/herself or the person or property of another.

**Patient Litigation:**

Dr. Fowler will not voluntarily participate in any litigation, or custody dispute in which Patient and another individual, or entity, are parties. Dr. Fowler has a policy of not communicating with Patient’s attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient’s legal matter. Dr. Fowler will generally not provide the records or testimony unless compelled to do so. Should Dr. Fowler be subpoenaed, or ordered by a court of law, to appear as witness in an action involving the Patient, Patient agrees to reimburse Dr. Fowler for any time spent for preparation, travel, or other time in which Dr. Fowler has made herself available for such an appearance at a rate of $350/hr.

**Psychotherapist-Patient Privilege:**

The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Dr. Fowler received a subpoena for records, deposition testimony, or testimony in a court of law, Dr. Fowler will assert the cycle therapist-patient privilege on Patient’s behalf until instructed, in writing, to do otherwise by Patient or Patient’s representative. Patient should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

**Fees and Insurance**:

Fees for service are $300/initial intake, $200/45-minute individual session, and $300/45-minute minute family or couples session. Fees are due prior to each session and are payable by cash, check, or major credit card (service provider fee added to credit card payments).

Insurance is not accepted. However, as a courtesy and upon request by Patient, Dr. Fowler will provide a super bill, which Patient may choose to send to his/her insurance company in the event Patient would like to subsidize a portion of the fee incurred. No guarantees can be made regarding individual insurance companies’ willingness to reimburse treatment.

**Cancellation Policy**:

Patient is responsible for payment of the agreed upon fee of any missed session(s). Patient is also responsible for payment of the agreed-upon fee for any session(s) for which the Patient fails to give Dr. Fowler at least 24 hours notice of cancellation. Cancellation notice should be left on Dr. Fowler’s voice mail at (714) 494-3706.

**Message and Emergency Procedures**:

Dr. Fowler’s office is equipped with a confidential voice mail system that allows Patient to leave a message at any time. Dr. Fowler will make every effort to return calls within 24 hours (or by the next business day), however cannot guarantee the call will be returned immediately. Dr. Fowler is unable to provide 24-hour crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, Patient should call 911 or go to the nearest hospital emergency room. A 24-hour emergency hotline number will be provided for Patient to take home with today in the event Patient is in need immediate support.

**Termination of Therapy**:

Dr. Fowler reserves the right to terminate therapy at her discretion. Reasons for termination include but are not limited to: untimely payment of fees, failure to comply with treatment recommendations, conflict of interest, failure to participate in therapy, Patient’s needs are outside of Dr. Fowler’s scope of competence for practice, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party’s decision to terminate therapy, Dr. Fowler will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Dr. Fowler will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient if appropriate.

**Patient Rights**:

At any time, Patient may question and/or refuse therapeutic or diagnostic procedures or request additional information regarding the procedures. Please to not hesitate to discuss any concerns and/or complaints with me so that we can work toward a resolution. Concerns can also be brought to the attention of the Washington Department of Consumer Affairs or the Washington State Board of Psychology.

**Acknowledgements**:

By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed such terms and conditions with Dr. Fowler and has had any questions with regard to its terms and conditions answered to Patient’s satisfaction. Patient agrees to abide by the terms and conditions of this agreement and consents to participate in psychotherapy with Dr. Fowler. Moreover, Patient agrees to hold Dr. Fowler free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

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 Patient Name (please print)

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 Signature of Patient (or authorized representative) Date

I understand that I am financially responsible to the Dr. Fowler for all charges, including missed or cancelled sessions when less than 24-hour’s notice was provided.

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 Patient Name (please print)

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 Signature of Patient (or authorized representative) Date

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 Signature of Dr. Fowler Date