P. Delia Brinton, MFT
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Informed Consent for Treatment

The following office policies and agreements are offered to facilitate our work together. The goal is to have minimal interruptions in your therapy as well as respecting the commitment we both make to your process. Please let me know if you have any questions or discomfort regarding the information so that we may discuss it.

I, ___________________, hereby authorize Delia Brinton, MFT to provide psychotherapy on a 50-minute per session basis for a period of time to be determined by mutual agreement. I understand that the purpose is (1) to improve my interpersonal relationships; (2) to increase my satisfaction in my personal and/or professional life; and/or (3) to deepen my inner work, but there is no guarantee that this will occur. I also understand that it is common to experience uncomfortable feelings in the course of therapy; these experiences are often part of a natural process and may help point the way to change. Initials__________

I understand that maximum benefit will occur with consistent attendance and that I will keep regular appointments. If I need to cancel or change an appointment I will give as much advance notice as possible. I agree to pay for a missed appointment if, ***for any reason***, I have not given at least 24 hours notice. Initials__________

I understand that Ms. Brinton may be out of town for conferences/ meetings or vacation/ family times (an average of six to twelve periods per year that require canceling/changing client appointments); when circumstances permit (i.e., less than a week absence), she will attempt to reschedule appointments to accommodate clients within that week. She will give advance notice of times when she will be gone, whenever possible. On her answering service, she will leave the name and number of a qualified professional to call in her absence. When she is in town or out of town briefly (i.e., for a few days only), she checks messages regularly; however, she is not available by phone on a 24 hour basis and she does not carry a pager. In case of an emergency, I understand that I may call the Psychiatric Emergency Service at Marin General Hospital at 499-6666. Initials_________

I understand that payment of $______is due at the beginning of each session unless other arrangements are made. I understand that the fee may periodically be increased (usually once a year); one month notice will be given before a fee increase. I understand that Ms. Brinton's full fee is $____ and she may, at times be able to offer a sliding scale to a fee of $_____ if circumstances warrant that. I understand that if I wish to bill an insurance carrier, Ms. Brinton will provide a statement and it is my responsibility as the client to follow through. I understand that phone calls over 10 minutes in length are usually billed on the basis of the hourly fee. I understand that I am free to terminate the therapy at any time; also I understand that discussion of ending therapy over a few sessions is likely to be a process that is beneficial to me. I understand that this is highly recommended. If there are financial concerns, Ms. Brinton will offer sliding scale arrangements specifically for these sessions/this session. Initials_____

For couples and families in therapy: If one member of the family or couple shares something with the therapist which is unknown to the other (s), it is acknowledged that such withheld information may radically undermine the potential of the therapeutic work. Therefore, Ms. Brinton has a "no secrets policy." Ms. Brinton will assist the clients in being able to communicate to each other and ultimately toward full and appropriate disclosure in the therapy.
Initials_____

Confidentiality Notice: The confidentiality of client information and records received or documented during the course of psychotherapeutic treatment is protected by both the legal and ethical standards pertaining to Marriage and Family Therapy. In general confidentiality is mandated and all conversations and documents pertaining to a clients' history will remain strictly confidential and privacy will be protected by the therapist. Information will not be released to any other individual or organization without the prior written authorization of the client. However there are permitted exceptions described below.
Initials_______

There are legal and ethical regulations that have created certain exceptions which allow for disclosure of information. These include the following situations, but are not limited to these:

1. Suspected child abuse or neglect. If information is obtained during the course of treatment that a minor is or may be the victim of abuse or neglect, this information will be released immediately to appropriate authorities.

2. **Suspected elder abuse or neglect.** If information related to abuse/neglect of a person 65 or over is obtained during the course of treatment, this information will be immediately release to appropriate authorities.
3. **Suspected intention to do serious harm to another person.** If intent to harm another person is revealed by the client during the course of treatment, information will be shared as necessary to prevent this harm.
4. **Suicidal intent.** The therapist may disclose information to other regarding the client's mental status if suicide or self-harm is determined to be a risk.
5. **Court Order.** Disclosures may be compelled by a judge, coroner, arbitrator or others in the legal system.

Initials_______

I have read and understand these policies.

____________________________________ ______
Client Signature Date

Print Name

Address

Phone Number (s) May leave message May not leave message