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AGREEMENT

This document contains important information about my professional services and business practices. Please read it carefully. It will represent an agreement between us, unless it is amended in writing or terminated.

Fees: Fees are charged per session and are to be paid weekly at the time of the meeting. Your fee will be $_____ per 50 minute session, unless otherwise established below. You may be charged for telephone calls (see below). Periodically, I will raise my fees. Checks need to be made out to Dora Futterman, Psy.D. You are responsible for any incurred fees that your insurance company fails to pay.

Failure to pay: Failure to pay as agreed to above is a breach of your fiduciary obligation and, under California law, I may use legal means to get paid. In the event that your account is unpaid and you have not arranged a payment plan, I might use a collection agency. The only information I would give to a collection agency or the court would be your name and address, the dates we met for professional services, the amount due, and copies of previous statements.

Cancellation policy: Please read and sign the attached statement.

Telephone calls: Messages can be left for me at (925) 640-8078. I check for messages throughout the day Mondays through Fridays and less frequently on weekends. In cases of emergency, contact your county crisis line (this number can be found in your local phone book or through phone information) or call 911. If you need to have a phone conversation between appointments, I will make every effort to talk to you at a mutually convenient time. I do not charge for the first ten minutes of telephone time per week, after which you will be charged $2.60 per minute. This policy also applies to any collateral telephone conversations or meetings which you have authorized with physicians, school personnel, or others.

Vacation: When I am on vacation or otherwise unavailable for appointments, I will leave the name and number of someone to call in the event of an emergency.

Recording: You agree that you will not record images or audio during sessions by any means, unless I have given you express and written permission to do so.

Texting, Email, and Social Media: Because these modes of communication put your privacy at risk, I severely restrict my use of these media. Email is not a secure means of communication, so I avoid using it as much as possible. Please do not email me about personal or clinical matters. If you need to discuss a clinical matter with me, feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. Please use texts to me only regarding things like setting and changing appointments. The telephone or face-to-face setting simply is much more secure as a mode of communication.

I do not engage with clients over social media, because it carries too much risk of revealing confidential information about you.

Dog **in the Office:** You acknowledge that I have informed you that a dog may be present in the office during sessions.

Consultation: It is possible that I will consult with another professional about your treatment. In such circumstances, I do not reveal any identifying information. This person also would be bound by professional ethics to keep any information that is discussed confidential.

This Agreement is in effect from this date until treatment is terminated either by the client or by the psychotherapist. The signatures below show that I have read, understand, and agreed to the policies above.

Signature: _____ Date: _____

Printed name: _____

Spouse or partner signature: _____ Date: _____

Printed name: _____

Parent or guardian signature: _____ Date: _____

Printed name: _____

CONSENT TO TREATMENT

While the course of psychotherapy will be designed to be helpful, there is no guarantee that it will be successful in improving your situation. Please understand that, even when it is successful, psychotherapy may, at times, be difficult and uncomfortable. Your participation is voluntary and you have the option to terminate treatment at any time.

Your signature below signifies that you understand and agree to the following:

1. I authorize and request my treating provider to carry out psychological assessments and treatments as deemed advisable.
2. I consent to the release of information necessary for any billing or other purposes necessary for reimbursement.
3. In general, the confidentiality of all communications between a client and a psychologist is protected by law, and the psychologist can only release information about my treatment to others with my written permission. However, there are some situations in which the psychologist is legally entitled or even required to release clients' protected health information without the client's authorization. Therefore, I acknowledge that under California law there are certain circumstances where the psychotherapist is required to give information about me without my consent:
    a. If a client or a client's family member communicates to a therapist a threat of serious harm by the client to an identifiable person or persons, the psychotherapist must warn that person and notify law enforcement.
    b. If the psychotherapist suspects child abuse or neglect or that an elderly or dependent person is being abused, a report must be made to the appropriate agency.
    c. If a client is dangerous to self or others or is unable to care of him- or herself, measures to keep the client safe must be taken.
4. I understand that information, records, and/or testimony about me or my family must be provided in the event of a court order. In litigation or other official proceedings, this information may have to be provided without my specific consent.
5. I understand that this consent covers me and any of my minor children involved in treatment.

This Consent is in effect from this date until treatment is terminated either by the client or by the psychotherapist. The signatures below show that I have read, understand, and agreed to the policies above.

Signature: _____ Date: _____

Printed name: _____

Spouse or partner signature: _____ Date: _____

Printed name: _____

Parent or guardian signature: _____ Date: _____

Printed name: _____