SILICON BEACH PSYCHOTHERAPY

Informed Consent and Confidentiality

Name: _____ **Name:** _____
Address: _____
City, State, Zip code:_____
Phone: _____ **Phone:** _____
Email: _____
Email:_____
Birthdate: _____ **Birthdate:**_____
Emergency Contact (Name and Phone Number):
_____

PLEASE NOTE: Sessions are 50 minutes long. The client is responsible for payment of fee at the beginning of each session, unless other arrangements are made in advance. The client will be charged *the entire fee* for appointments missed without notification and for appointments cancelled without 24 hours notice. The client accepts responsibility for payment of all fees, including any claims submitted to an insurance company that are denied for any reason.

All matters discussed are strictly confidential, except in any of the following circumstances: 1. When the client gives permission for the therapist to share specific information with others (e.g. physician or insurance company), 2. When the therapist has reason to suspect that a child, elderly person, or dependent adult in the client's life has been physically, sexually, emotionally, or financially abused, 3. If the therapist has reason to believe that the client intends to physically harm another person, or 4. If the therapist has reason to believe that the client is acutely suicidal, the therapist will take measures necessary to protect the client's safety, including breaking confidentiality.

Signature: _____ Date: _____

Signature: _____ Date: _____

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11949 Jefferson Blvd. #102, Culver City, California 90230
Natalie Procter, Associate MFT #111069
Supervised by Susanna De Mari LMFT #42715