Informed Consent for Psychotherapy

Client: _____

Clinical Therapist: Veronica San Juan, LMFT
#100280

Limits of Confidentiality: (1) As a **Mandated Reporter**, I am required to notify a child protective agency if **I observe, have knowledge or reasonably suspect a child has been the victim of abuse (P.C. 11166[a])**. **(2)** Under the **Tarasoff Law** I have a duty to **make reasonable efforts to warn and attempt to protect a reasonably identifiable victim from a patient's threatened violent behavior and notify law enforcement. (3)** Consistent with Welfare and Institutions Code 5150- confidentiality may be limited where **a minor is a danger to self, others, or is gravely disabled.**

Release of Client Records: Client information/records may only be disclosed with consent in accordance with Welfare and Institutions Code 5328.

Benefits/Risks of Therapy: Many people benefit from psychotherapy with improvements typically noted in areas including home, school/work, or community. However, a precise and positive outcome cannot be predicted or guaranteed. A negative reaction to the therapeutic process is possible and should be discussed as it becomes evident.

Alternative to Therapy: Alternatives to psychotherapy exist and may be explored relative to the client's presenting problems.

Community Contact Policy: It is my policy that should I encounter a client/guardian in the community- I will not initiate contact to protect your confidentiality.

Complaints: Complaints may be directed to Veronica San Juan, LMFT.

Missed Appointments: Missed appointments are an inconvenience for our office; please provide a minimum of 24 hours' notice for cancellations. A pattern of missed appointments may result in the loss of treatment time slot, or closing of the case.

Right to End Treatment: Services can be ended by the client/therapist at any time.

As the primary therapist for the client identified above, I certify that I have provided and discussed the information herein with the client.

Therapist: _____ **Date** _____

With my signature below, I acknowledge that all of the information above has been explained to me. I give consent for mental health services for myself.

Client: _____ **Date** _____