

## **Disclosure Statement & Agreement for Psychotherapy Services**

Welcome! This document is intended to provide important information to you regarding your psychotherapeutic treatment. Please read the entire document carefully and be sure to ask any questions that you may have regarding its contents.

### **Information about Your Therapist**

Emily R. Gombos, M.A., Licensed Marriage & Family Therapist  
License #44604 issued by the State of California Board of Behavioral Sciences  
In Private Practice/Self-Employed

#### Education:

Candidate, Psychodynamic Psychotherapy Program  
*Newport Psychoanalytic Institute*  
Master of Arts in Psychology, Marriage & Family Therapy emphasis, with Honors  
*Chapman University*  
Bachelor of Arts in Psychology  
*University of California, San Diego, Revelle College*

#### Postgraduate Training:

Relationally Oriented Psychoanalytic Case Formulation  
Interpersonal Neurobiology  
Mindfulness Meditation

Please feel free to ask questions at any time about my background, experience, and professional orientation.

### **Fees**

The full fee for service is \$150 per individual therapy session (50 minutes).  
The full fee for service is \$240 per conjoint (couples/family) therapy session (80 minutes).  
Reduced fee services are available on a limited basis.

Fees for telephone contact are as follows:

First 10 minutes:	Free
11 to 30 minutes:	Half of hourly fee
31 to 50 minutes:	Hourly fee

Check, cash, and credit/debit card are accepted for payment. Returned check fees apply.  
Account statements will be provided to you regularly.

As is legally required, your fee will be agreed upon in the first session, and may be adjusted as circumstances change. Fees are payable at the beginning of each session. If you prefer, you may pay for future sessions in advance. Cost of living increases may occur on an annual basis. Interest may be charged on accounts past due. Regular rates will apply for any document preparation, court work, or testing.

If for some reason you find that you are unable to continue paying for your therapy, please let me know. I will help you to consider any options that may be available to you at that time.

### **Insurance**

Please inform me if you wish to utilize health insurance to pay for services. The amount of reimbursement depends on the requirements of your specific plan. Insurance companies generally limit coverage to certain diagnosable mental conditions. Please understand that you are responsible for verifying and understanding the limits of your insurance coverage, as I am unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with me.

### **Confidentiality**

State law and professional ethics require all communications between us to be held in strict confidence unless you provide written permission to release information about your treatment, or if the situation falls under one or more of the following exceptions to confidentiality:

1. If there is suspected child abuse, elder abuse, or dependent adult abuse.
2. If you are a danger to yourself or others.
3. If you are gravely mentally disabled.
4. If a judge requires disclosure of records.

### Notes on Confidentiality

- Minors
  - Communications between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, I, in the exercise of my professional judgment, may discuss the treatment progress of a minor client with the parent or caretaker by providing a general summary, upon request. Clients who are minors and their parents are urged to discuss any questions or concerns that they have about this with me.
- Conjoint Therapy
  - If you participate in couples or family therapy, I will not disclose confidential information about your treatment to any outside party unless all person(s) who participated in the treatment with you provide their written authorization to release such information. However, it is important that you know that I utilize a "no-secrets" policy when conducting conjoint therapy. This means that if you have an individual session with me while concurrently in conjoint therapy, I am permitted to use information obtained in the individual session when working with other members of your family. Please feel free to ask any questions about my "no secrets" policy and how it may apply to you.
- Guests
  - If you wish to invite a guest for a one-time visit into a therapy session, your confidentiality cannot be guaranteed. A signed agreement will be required before a guest can be introduced into the therapeutic process.

- Professional Consultation
  - I may at times speak with professional colleagues about our work without asking your permission, with all identifying information thoroughly disguised.
- Communications
  - All records as well as notes on sessions and phone calls can be subject to court subpoena under certain extreme circumstances.
  - Most records are stored in locked files but some are stored in secured electronic devices. Cell phones, portable phones, faxes and e-mails are used on some occasions. Please understand that all electronic communication compromises confidentiality.
- The Patriot Act of 2001
  - This federal law requires therapists in certain circumstances to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the client that the FBI sought or obtained the items under the Act.

### **The Therapeutic Relationship**

Because of the nature of psychotherapy, the therapeutic relationship has to be different from most relationships. It may differ in how long it lasts, in the topics we discuss, or in the goals of our relationship. It must also be limited to the relationship of therapist and client only. If we were to interact in any other ways, we would then have a "dual relationship". Therapy professions have rules against such relationships to protect us both.

- I cannot be your supervisor, teacher, or evaluator.
- I cannot be a therapist to my own relatives, friends (or the relatives of friends), people I know socially, or business contacts. I cannot have any other kind of business relationship with you besides the therapy itself.
- I cannot give legal, medical, financial, or any other type of professional advice.
- I cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client.

There are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions. A therapist offers you choices and helps you consider what is best for you. Also, when therapy is completed, I will not be able to socialize with you like your other friends.

You should also know that therapists are required to keep the identity of their clients confidential. Therefore, if you have any particular preferences about public meetings, let me know, otherwise I may ignore you when we encounter each other in a public place in order to protect your confidentiality.

My duty as therapist is to care for you, but only in the professional role of therapist.

### **Appointment Scheduling and Cancellation Policies**

Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome.

In order to cancel or reschedule an appointment, you must notify me at least 24 hours in advance of your appointment. If you do not provide me with at least 24 hours notice in advance, you are responsible for payment for the missed session. Exceptions may be made in cases of extreme illness/emergency.

### **Therapist Availability/Emergencies**

I am available for regularly scheduled appointment times. Dates of vacations and other exceptions will be given out in advance, if possible.

Telephone contacts between office visits are welcome. However, they are best kept brief as important issues are better addressed in person, within regularly scheduled sessions. You may leave a message for me anytime on my confidential voicemail. I am available to return messages at these times:

Monday – Thursday	9am to 7pm
Friday	9am to 5pm
Saturday	9am to 12pm

In the event of an emergency involving a threat to your safety or the safety of others, please call 911 or go to your nearest emergency room.

### **About the Therapy Process**

It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Due to the varying nature and severity of problems and the individuality of each client, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

### **Termination of Therapy**

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. We will discuss a plan for termination as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If it is determined that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

**Commitment**

Therapy is a significant investment of time and money. I encourage you to make a commitment to getting the most from your sessions by attending regularly and being open to the experience of making a change in the direction of your goals. Please ask any and all questions you may have about the process of therapy, the risks and benefits of the work, and anything else that comes to mind. I look forward to working with you!

**Agreement/Signature**

*I have read this informed consent completely and have raised any questions I might have about it with my therapist. I have received full and satisfactory response and agree to the provisions freely and without reservations.*

*I understand that my therapist is responsible for maintaining all professional standards set forth in the ethical principles of her professional association, as well as the laws of the state of California governing the practice of psychotherapy and that she is liable for infractions of those standards.*

*This agreement constitutes our professional contract. Any changes must be signed by both parties. I have a right to keep a copy of this contract.*

Printed Name: \_\_\_\_\_  
(Client)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Client)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/Conservator/Guardian)

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**Statement of the Therapist**

This document was discussed with the client and any questions were discussed. I have assessed the client's mental capacity and found the client capable of giving an informed consent at this time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Therapist)