David J. Frankel, Ph.D.
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Adult, Child and Family Therapy
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CONSENT FOR TREATMENT

This is to certify that I give permission to David J. Frankel, Ph.D. to provide psychotherapy for me.

The Process of Psychotherapy:

I will be treated with respect and honesty throughout treatment. I am expected to benefit from treatment, but there are no guarantees. Outpatient psychotherapy does not have significant risks. Maximum benefits will occur with regular attendance, but I understand that I may feel temporarily worse while in treatment. Attempting to resolve issues that brought me in to therapy may result in changes that were not originally intended. Change will sometimes be easy and swift, but more often it will be slow and frustrating.

I understand that if I can benefit from any treatments Dr. Frankel cannot provide, he will assist me in obtaining those treatments. At some time from the first to the third meeting, Dr. Frankel will assess if he can be of benefit to me. Dr. Frankel will not take clients whom, in his opinion he cannot help. In such a case, at the end of the meeting, he will give me referrals I can contact. If at any time I wish another professional's opinion, Dr. Frankel will assist me in finding someone qualified to do this. Psychotherapy never involves dual relationships. I understand that I have the right to terminate the therapeutic relationship at any time without fault. If I choose to do so, I understand that Dr. Frankel can provide me with names of other qualified professionals. Should I have any complaints or questions regarding the practice of psychology in the State of California, I understand that I can contact the Department of Consumer Affairs. Their phone number is: 800-633-2322 or 916-263-2424. I can also contact them in writing at the following address: Department of Consumer Affairs, Allied Health Complaints, 1430 Howe Avenue, Sacramento, CA 95825.

Confidentiality:

I understand that while under most circumstances all communication between a client and the therapist is confidential, California State Law mandates the reporting of actual or suspected child or elder abuse to the appropriate agency. I understand that it has also been upheld that if an individual intends to take harmful or dangerous action against another, it is the therapist's duty to warn the person, or the family of the person, who is likely to suffer the results of harmful behavior. Similar actions are taken with clients who may have suicidal thoughts and desires, or become gravely disabled. Every reasonable effort will be made to appropriately resolve these issues or to notify me before such a compromise of the client - therapist relationship is made.

I agree that should there be legal proceedings, neither me, nor my attorney nor anyone else acting on my behalf will call on Dr. Frankel to testify in court, or at any other proceedings, nor will a disclosure of psychotherapy records be requested. Nontheless, disclosure of therapeutic communication may be required in the course of a legal proceeding. I understand that on my request, Dr. Frankel may release information to an agency or person I specify unless Dr. Frankel assesses that releasing such information might be harmful in any way.

In couples and family therapy, confidentiality and privilege do not apply between the couple or among family members. I understand that Dr. Frankel will use his clinical judgement when deciding whether to reveal information between family members. I understand that in conducting individual psychotherapy with an adolescent or child, Dr. Frankel may elect to keep the contents of the psychotherapy confidential from the adolescent or child's legal guardian.

Fees:

I understand that unless otherwise negotiated, the standard rate for a 50 minute psychotherapy session is 240.00. This fee is higher for inpatient consultation. I understand that this fee must be paid either at the end of each session, or at the end of the month unless other arrangements have been made. I understand that an interest rate of 1.5 percent per month will be charged on all overdue balances. I understand that a collection agency or the legal system may be utilized to obtain payment of any bills I may accrue. I understand that I will be financially responsible for all costs associated with collecting overdue balances I may accrue. I am financially responsible for this treatment and for any balance not covered by my insurance carrier.

Cancellation:

I understand that I am liable for the full fee for a scheduled session, should I not attend the session and fail to cancel the appointment 24 hours in advance.

Telephone and Emergency Procedures:

I understand that Dr. Frankel's office number is 415-927-7067. Dr. Frankel does not generally use email for emergencies and clinical advice. Dr. Frankel is not always immediately available by telephone. I understand that I should contact either the police at 911, or my local crisis unit in the event of an immediate crisis or emergency. A copy of this authorization shall be considered valid.

Signed:_____

Date:_____
(Client)

Signed:_____

Date:_____
(Therapist)