JoLee Walker, MA, LMFT
Informed Consent

This Informed Consent Form is intended to provide sufficient information for you to make informed choices about entering and continuing therapeutic treatment. The specifics of the treatment goals and the steps to achieve these goals will be discussed at the first appointment. Your participation and understanding of the treatment goals is essential for the best benefit of therapy.

THERAPIST'S EDUCATION AND TRAINING Your therapist, JoLee Walker, M.A, LMFT, is a CA Licensed Marriage and Family Therapist. She obtained her graduate degree from University of Santa Monica in Counseling Psychology with an emphasis in Spiritual Psychology. She is a member of CAMFT—the California Association for Marriage and Family Therapy.

WHAT TO EXPECT – BENEFITS AND RISKS There are benefits and risks in seeking individual, marital or family therapy. Some of the potential benefits of therapy include developing your ability to handle or cope with your relationships and providing you with greater insight into your personal goals and values. In working to achieve these benefits, however, you may address issues or make changes that you may experience as distressing. These risks of therapy include, but are not limited to: feelings or circumstances becoming worse before they get better; changes in your emotional state, such as feelings of depression or anxiety; the possibility of changes in perception or behavior; and changes in occupational, social, or personal relationships.

RIGHTS OF CONFIDENTIALITY Your therapist pledges to uphold privacy and confidentiality concerning your treatment process and records as outlined by California Statute. JoLee will do everything within her power to protect the physical records of treatment and the information contained therein, including safeguarding their use, transportation and storage. It is understood that all information between client and therapist is held strictly confidential, and the therapist will not release any information about therapy unless permitted by law or:

1. It is agreed upon in writing and complies with State Laws.
2. The client presents an imminent danger to self.
3. The client presents an imminent danger to others.
4. Child/Elder abuse/neglect is suspected.
5. As necessary for continuity of care.
6. If a judge determines that our discussions are not confidential, a judge may request specific information.
7. As requested by a court appointed attorney for a child involved in court proceedings.

It is understood that in cases #2, #3, and #4, the therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. If I participate in group counseling, I agree not to discuss any details of the group outside of the counseling sessions.

HELP FOR EMERGENCIES In the case of an emergency, please call 911 or the crisis line at (800) 479-3339.
You may attempt to contact JoLee for emergency assistance and she will do her best to return your call promptly, however she cannot guarantee to see you as soon as you need.

PATIENT CONSENT TO RELEASE OF INFORMATION I consent to information release about my case (or my child's case) with the referral source. Where applicable, I further consent to the release of information to my health plan for claims, certification/case management/quality improvement and other health plan purposes.

GENERAL CONSENT FOR TREATMENT I further authorize and request that my therapist carry out treatment that now or during the course of my care as a client are advisable. I understand that the purpose of these treatment practices will be explained to me upon my request and are subject to my agreement.

GENERAL CONSENT FOR TREATMENT (If client is a child or dependent) On the patient's behalf, I (the legal Guardian or Legal Representative) legally authorize JoLee Walker to deliver mental health care services to the client. I also understand that all policies in this statement apply to the client I represent. I acknowledge that my child's records are considered confidential except in the above stated exceptions.

SESSION FEES The fee for a 50-minute individual therapy session is $150. payable to JoLee Walker. Therapeutic services delivered over the phone are subject to the same hourly rate as regular sessions and will be billed on a pro-rated basis. Fees are re-evaluated and subject to change every six months. JoLee Walker does provide services at a lower rate for those whom these fees are at out of reach on a limited basis.

PAYMENTS & INSURANCE REIMBURSEMENT Clients are expected to pay the fee, or the co-payment designated by your health insurance plan, at the end of each session. Clients who carry health insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. As a courtesy, JoLee Walker, will bill your insurance company, and wait a reasonable time for payment, however the client is ultimately responsible for the full payment in a timely manner. It is your responsibility to verify the specifics of your coverage. If your account is overdue or unpaid, JoLee Walker, can use legal means (courts, collection agencies) to obtain payment. Further, you authorize direct payment of mental health benefits from insurance to JoLee Walker, LMFT.

PAYMENT POLICY Payment in full is expected at the time of service, unless alternate arrangements are mutually agreed upon. Payment is accepted in the form of cash, check or electronic transfer. When making payment by check, please have your check written before the start of the session, whenever possible. All checks returned for non-sufficient funds (NSF) are subject to a $20 returned check fee.

CANCELLATION POLICY The time for which your appointments are scheduled has been reserved for you. You are required to give notice of cancellation at least 24 hours prior to a scheduled appointment. If you do not give 24-hour notice or fail to show for a scheduled appointment without prior notification, you will be charged the full session fee for private pay and the contracted session fee paid by your health insurance. Health insurance does not reimburse for missed sessions. Exceptions can be made in the event of an emergency only; however, you are asked to call as soon as possible to inform your therapist of the circumstances.

I, JoLee Walker, have attempted to answer your questions about treatment satisfactorily. If you have further questions or concerns, I will do my best to answer them or find answers for you. Your signature represents a statement that you have read and understood the information above and as outlined by me, JoLee Walker, have received a copy of this Informed Consent form, have been made aware of your rights and the privacy practices of this office, agree to comply with fees and policies and consent to the therapy process as described above. You have the right to withdraw your consent for treatment at any time.

______________________________ ____________
Client Signature Date

______________________________ ____________
Client Signature Date

______________________________ ____________
Parent/Guardian Signature (if client is under 18) Date