**Odette Boyd, MA. MBA.**

5101 E. La Palma Ave, Suite 100 ⚫ Anaheim, CA 92807⚫ (442) 229-5636

⚫Registered Psychological Assistant, PA94024879 ⚫ Supervised by Janira Jacoubs-Beye, Psy.D., PSY23677

Consent for Treatment & Office Policies

***The Process of Psychotherapy***

Psychotherapy provides you with an opportunity to understand more deeply the problems you are experiencing and can lead to important changes. To be successful, the work requires a joint effort between patient and therapist. Additionally, progress in psychotherapy may vary depending upon the particular problems being addresse and can depend on factors including your motivation, effort, and life circumstances such as your interactions with family and friends. You may experience uncomfortable feelings during the course of therapy. These are an important part of the process of therapy, and often provide the impetus for greater understanding and growth. If at any time you wish to have another professional opinion, or to seek treatment elsewhere, I can refer you to other qualified professionals. You are free to discontinue the therapeutic relationship at any time.

***Confidentiality***

All information disclosed within sessions and records are confidential, and may not be revealed to anyone without your written permission, except where disclosure is required by law. Under California State Law disclosure may be required in the following circumstances: (1) When there is a reasonable suspicion of child abuse or neglect, (2) when there is reasonable suspicion or elder/dependent adult abuse, (3) when a patient presents a danger to himself or to others, or is gravely disabled, (4) pursuant to a legal proceeding (e.g. subpoena by a Court). Additionally, disclosure of confidential information may be required by your insurance carrier in order to process a claim. In this circumstance, only the minimum amount of information will be communicated to the carrier.

***Payment for Services***

Patients are expected to pay for services at the time they are rendered unless other arrangements have been made. The fee for a 50-minute psychotherapy session is \_\_\_\_\_\_. Telephone contact in excess of 10 minutes will be billed at the hourly rate of \_\_\_\_\_\_ beginning at the time of the initiation of the call. Please notify me if any problems arise during the course of therapy regarding your ability to make timely payments.

***Cancellation***

Patients are responsible for all scheduled sessions. Upon availability of the therapist, planned cancellations may be rescheduled within two weeks of the canceled appointment provided at least 48-hour's notice. Cancellations within 48 hours of an appointment will be billed at the above rate of \_\_\_\_\_\_. You are allotted two weeks-worth of appointments per year during which your appointments will be held at no charge. You may choose to use one of these sessions at any time during the year. Bear in mind that you may also need to use these two weeks for vacations.

***Emergency Procedures***

If you need to contact me between sessions, please leave a message on my voice mail at (442) 229-5636 and your call will be returned. If an emergency situation arises, please indicate it clearly in your message. If you need to talk with someone immediately, call the 24-hour Crisis Hot line at (844) 549-4266 or call 911 for life-threatening situations. You may also visit your nearest emergency room for immediate assistance.

***Psychological Assistant Disclosure***

As a psychological assistant, Ms. Boyd is currently employed and supervised by Janira Jacoubs-Beye, Psy.D., PSY23677. In order to insure the highest standard of care, supervisors meet with their psychological assistants weekly and review the progress of their work with you. Dr. Beye is available for consultation upon your request.

All payments for services must be made out to Dr. Janira Jacoubs-Beye, 5101 E. La Palma Ave., Suite 100, Anaheim, CA 92807.

If you have any questions about this supervisory relationship, please talk to me. Signing this form acknowledges your informed consent for treatment by a psychological assistant under clinical supervision.

*I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read and fully understand this consent for treatment and office policies form, and voluntarily agree to undergo psychotherapy with Ms.Boyd. I also acknowledge that it is my responsibility to pay for services rendered to me by Ms. Boyd. I understand the limits of confidentiality and office policies regarding fee payment and cancellations.*

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Phone Number(s)                Email

*The patient understood and freely agreed to the terms listed above.*

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Odette Boyd, MA, MBA. Date