Wellspring Psychological Associates
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Therapy Information and Consent Form

This information sheet has been prepared to acquaint you with the issues that frequently arise over the course of psychological treatment. The ethics of our profession demand that we respect the dignity and integrity of those who seek our help. We have found it helpful to be as clear as possible about the business aspects of treatment. Your signature at the end of this information indicates that you have read, understood, and agree with these provisions. If you have questions, please discuss them with me before signing.

Service Provider: Suzanne Stubblefield is a licensed clinical psychologist. She provides therapy to a variety of clients including adults, adolescents, children, and couples, using psychodynamic, cognitive-behavioral, and systems approaches. Dr. Stubblefield is open to the integration of faith and psychology in the therapeutic process.

Confidentiality: Historically, complete confidentiality has applied to communication between psychotherapist and client. More recently, however, legal developments in California have occurred which require clarification regarding the issue of confidentiality.

- If you are an adult, anything you do or say in the context of psychotherapy is privileged (private) with these exceptions:
  1. If you are behaving in a way that poses a threat of physical harm to yourself or another person, privilege is waived.
  2. If child, elder, or dependent adult abuse has occurred, the law requires that it be reported. We will strive to work alongside you in your best interests.
  3. If you are using confidentiality as a means of avoiding legal punishment, privilege is waived. Therapists may not aid or abet the perpetration of a crime.

Of course, all actions taken under these provisions will be discussed with you fully and in advance, whenever possible.

- Parents or guardians of minors hold privilege, and are entitled to information communicated to their children in psychotherapy. Ethics require us to communicate information only in ways we deem helpful. With adolescents, we may request that you waive this privilege to enhance the effectiveness of therapy.
- Patients whose costs are covered by insurance should be aware that coverage always requires a diagnosis. We will be glad to discuss diagnosis with you, and will assume that your giving us your insurance information gives us permission to give your diagnosis to that company. Questions regarding your insurance company's confidentiality policies must be submitted to them directly.
- You may need to have records of your sessions sent to other healthcare professionals. On these occasions you will be asked to sign a "release of information" form, *without which we will not send records.* A $25 fee will be charged for this service, payable before records are sent.

Fees: We understand that psychological evaluation and treatment can be costly. We encourage you to discuss any aspects of our fee structure with us at any time.

- Fees are established during the first visit. Fees remain constant over the course of treatment. It is customary to pay for professional health care services at the time of service. All checks are payable to *Dr. Suzanne Stubblefield* or *Wellspring Counseling.*

- Missed sessions are understandable from time to time. Our policy is that we should be notified at least 24 hours in advance of missed sessions. This allows us to offer that time to other clients. Sessions missed without 24 hours notice will be billed at the regular fee ____ (Please initial). We will make every attempt to accommodate your scheduling needs, however, late cancellations or last minute requests for change are disruptive to both client and therapist.

Telephone Contact: Telephone calls can be made to my confidential voicemail at (949) 229-0622. My scheduler Barbara Colvin checks my voicemail Monday – Thursday and will return your call or respond via text as soon as possible. I will return your call as soon as possible. Any private messages are sent directly to me. If an emergency arises and you are unable to get a hold of me, please go to a hospital emergency room or dial 911. If you would like to be able to receive a text message from our office, please initial here _____ and give me your cell phone number _____.

Medication: We do not provide medication. We will be glad to consult with your physician regarding psychological aspects of medication, but all decisions regarding medication should be handled by your physician.

Wellspring Psychological Associates: I work with a group of independent mental health professionals, under the name *Wellspring Psychological Associates*. This group is an association of independently practicing professionals who share office space and certain administrative functions. While the members share a name and office space, you will, however, make your payments to *Dr. Suzanne Stubblefield*. I am completely independent in providing you with clinical services and I alone am fully responsible for those services. As an independent practitioner, I am solely responsible for all matters concerning your clinical care and all questions about that care should be addressed to me. My professional records are separately maintained, and no member of the group can have access to them without your specific, written permission.

I, the client (or parent/guardian), have read the above information. I understand and fully accept the conditions as stated in each paragraph of this consent form.

_____

Client's/Parent/Guardian Signature **Date**