

Michael Mombrea  
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## **Informed Consent**

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

### **Fees and Insurance**

The fee for service is \$160 per 50 minute individual therapy session.  
Fees are payable at the time that services are rendered.

### Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, your therapist will not disclose information communicated privately to him or her by one family member, to any other family member without written permission.)

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child, dependent adult or elder abuse. Therapists may also be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. (Alternate version below for therapists who utilize a "No Secrets" Policy)

### Minors and Confidentiality

Communications between therapists and patients 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, your therapist, in the exercise of his professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

### Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist 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 are expected to notify your therapist at least 24 hours in advance of your appointment. If you do not provide your therapist with at least 24 hours' notice in advance, you are responsible for payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions.

### Therapist Availability/Emergencies

You are welcome to phone your therapist in between sessions. However, as a general rule, it is our belief that important issues are better addressed within regularly scheduled sessions. You may leave a message for your therapist at any time on his confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s),

along with a brief message concerning the nature of your call. Non urgent phone calls are returned during the therapist's normal workdays within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call.

#### Therapist Communications

Your therapist may need to communicate with you by telephone or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

#### Consumer Information for Telemental Health Services

I, the undersigned understand that as a part of our therapy, Mr. Mombrea and I will sometimes utilize elemental health conducted remotely using videoconferencing technology or telephone. I understand that while nothing on the internet is 100% secure, Mr. Mombrea will make every reasonable effort possible to protect my security and privacy when conducting therapy in this format. I understand that Mr. Mombrea has chosen to utilize "doxy.me" videoconferencing software which utilizes state of the art encryption protocols and is fully compliant with HIPAA's privacy requirements. \_\_\_\_\_(Initials and date)

Name of Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_