Marin Stress & Anxiety Center
Jonathan Pofsky, MFT, CMT
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415-577-5338 www.marinstressanxietycenter.com

Informed Consent Form

- I have chosen to participate in the treatment of psychotherapy with Jonathan Pofsky, Licensed Marriage and Family Therapist. My participation is voluntary, and I am aware that I may discontinue receiving services at my discretion.

- I understand that all information I disclose to my therapist is held in strict confidentiality and may not be released without my written consent. There are some exceptions to this, which are allowed or mandated by state and federal law. Exceptions to confidentiality include situations where:
  - Client is a danger to his/her self or another person.
  - There is actual or suspected abuse or neglect of children/minors, elderly, or dependent adults. (My therapist is mandated by law to disclose this information to the proper authorities)
  - A valid court order has been presented.
  - Consultation with other professionals is needed. Only appropriate and necessary case specifics will be discussed.

- My psychotherapist may disclose any and all records pertaining to my treatment to my insurance company and/or primary physician as necessary for coordinating of treatment, submission and validation of claims, or case management. I may revoke this consent in writing at any time.

- I have been informed of the fees for services and I understand that I am responsible for these costs, unless there has been prior confirmation of insurance benefits eligibility by the therapist. I understand that it is my responsibility to contact my insurance company to determine the scope of mental health services covered by my policy. Fees may be paid in cash, check, or credit/debit card. All co-payments (if any) are to be paid by the client with each session.

- I understand that I am responsible for the full service fee if I should fail to give 24-hour notice to cancel an appointment or do not show up to my appointment. I understand that there are no exceptions to this policy. If I pay with insurance, I understand there will be a charge of the discounted rate (specific to my insurance plan) due for missed sessions within 24 hours that is not reimbursable through insurance.

- Psychotherapy sessions are 50 minutes in length. I understand that it is my responsibility to arrive to my sessions on time and that sessions will end promptly.

- I understand that some information discussed in the course of psychotherapy may be distressing to me, but may be necessary to help resolve my concerns. I understand that alternatives to psychotherapy may include medication treatment or no treatment.

_____
Signature

_____
Name (Print)

_____
Date