Laraine A. Tanzer, LCSW

License No. LCS23007

4540 Campus Drive, Suite 122, Newport Beach, CA. 92660

Tel. (949) 903-1823 Fax (949) 720-9808 Email: L.tanzer@sbcglobal.net

---

Informed Consent for Psychotherapy Consultation
(Individual, Couples, Family, Group)

Name(s):_____/_____

Address:_____

Home Telephone No._____Cell Telephone No(s)._____/_____

Referred by:_____

Please read the following information, sign and return one copy to me, retaining a second copy for your records if you wish.

The purpose of these initial session(s) is to determine your needs and to help you decide what form(s) of psychotherapy may be desirable, the goals you wish to accomplish, the risks and benefits of therapy and the appropriateness of my training, experience and scope of practice in meeting your needs. This session(s) are for assessment only. Any other psychological or counseling services are offered under a separate fee schedule and service agreement.

Appointments & Payment for Services: The fee for the Assessment Consultation session(s) is $__300.00___to be rendered at the time of service. The consultation session will be scheduled for 1.5 hours clinical time (80 minutes). A follow up consultation session may be required for me to complete a full assessment and for a therapeutic decision to be may whether our work together will continue.

The scheduling of an appointment involves the reservation of time specifically for you; canceling an appointment must be done two days (48 hours) prior to the scheduled time, in other words, 48 hour cancellation is required to avoid being charged the full fee for missed scheduled appointments_____**(initials).**
I agree to pay all legal fees that might be incurred by the therapist as a result of these assessments sessions._____(initial)

Health insurance reimbursements: Professional services are rendered and charged to the client and not to your insurance carrier or managed care company. If you wish, I will provide you with a statement of service(s) suitable to present to your insurance carrier or managed care company which you may submit for **possible** reimbursement. **Note: You may wish to check with your insurance carrier to see what they will and will not cover.**

Confidentiality: All information disclosed within session(s) is confidential and may not be revealed to anyone without your prior written consent. There are however, certain limitations to confidentiality. Disclosure is required when there is a reasonable suspicion of child, elder or

dependent abuse. It is also required when a client presents a serious threat of harm to another person. Disclosure may also be necessary when a client presents a danger of harm to himself/herself unless protective measures are taken. Although clients have a right to prevent confidential information from being included in a legal proceeding, there are certain exceptions when disclosure would be required. I understand that in some instances my confidentiality is limited by law and compromised by all forms of electronic communication. Note: Child, elder and dependent adult abuse and situations in which serious physical harm is threatened toward oneself or toward someone else must be reported as mandated by law.

I occasionally consult with other professionals about my work. Any consultant is also legally bound to keep information confidential. When using consultation I disclose only the information necessary to facilitate the therapeutic process; your name is not revealed and I take care to preserve your anonymity.

Please be aware that I use a cell phone for client calls. In some circumstances privacy may be at risk.

Emergency Availability: Generally I am **NOT** immediately available by telephone, however, I check my messages periodically throughout the day. Please leave a message and include where, when and how I can reach you in a timely manner. I will return your call within the next business day. If you are in crisis and you cannot wait for me to return your call, go to an emergency room or call 911.

Should you and I decide to continue services beyond the assessment session(s) an Informed Consent for Psychotherapy Treatment will be provided and agreed upon.

I have read and understood the above policies and consent to the initial assessment session(s).

Client(s) Signature(s):_____**Date:**_____

_____**Date:**_____

Therapist Signature: _____**Date:** _____

Release of Confidential Information:

Are you currently in therapy? _____yes _____no

If so, who is your current therapist? Psychiatrist?

1.Name:_____Phone:_____

Address:_____

2.Name:_____Phone:_____

Address:_____

Who are your past therapists? Psychiatrists?

3.Name:_____Phone:_____

Address:_____

4.Name:_____Phone:_____

Address:_____

Note: Professional ethics may require that therapists obtain pertinent records from current and/or previous psychotherapists and physicians in order to work effectively with you. I hereby give permission to the above therapist(s), doctor(s) to release their confidential records to:

Laraine Tanzer, LCSW
4540 Campus Drive, Suite 122
Newport Beach, CA. 92660

Phone: (949) 903-1823
FAX: (949) 720-9808

_____
(client signature) (date)

_____
(therapist signature) (date)