

AMY-LYNN GERBER
Marriage & Family Therapist
LMFT #103970
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Los Angeles, CA 90039
(213) 375-5731

CONSENT FOR TREATMENT

This is to certify that I agree to participate in individual psychotherapy with Amy-Lynn Gerber, a Licensed Marriage & Family Therapist.

1. I understand that Amy-Lynn Gerber is a licensed Marriage & Family Therapist in good standing with the California Board of Behavioral Sciences.
2. I understand that the standard therapeutic session is 50 minutes in duration.
3. I understand that that I will achieve the maximum benefits from psychotherapy by attending sessions on a regular and consistent basis.
4. I understand that I am financially responsible for all scheduled appointments. I understand that I will be charged the full fee for all sessions cancelled without at least 48 hours notice, or for Monday appointments cancelled after 5 p.m. on the previous Friday. I understand that if I arrive late for my appointment, the session will end at the regularly scheduled time and that I will be charged the full fee. I understand that if I am more than 15 minutes late for my appointment and have not notified the therapist that I have been delayed, the session will be considered cancelled and that I will be charged the full fee. I understand that my therapist reserves the right to utilize third party debt collection services for any fees owed that are not paid within 30 days. My therapist keeps my credit card on file via Ivy Pay to avoid this situation for all parties.
5. I understand that my session time has been reserved for me on a weekly basis. I understand that my regularly scheduled session time will not be reserved for me if I cancel more than two appointments in any one month period.
6. I understand that if I do not attend therapy for 3 weeks in a row without scheduling another appointment, my file will be closed and the therapy will be considered terminated. I understand that even if my file is closed, if I decide to recommit to therapy, my file will be reopened as soon as I make a new appointment.
7. I understand that therapy is most effective when client and therapist are both fully engaged in the therapeutic process; therefore I agree to turn off cell phones and all other electronic devices for the duration of each session.
8. I understand that I am expected to benefit from treatment, but that there are no guarantees. Outpatient psychotherapy does not have significant risks, but I understand that I may feel temporarily worse at times during treatment.
9. I understand that, while therapy is intended to help me achieve my life and relationship goals, all decisions regarding those goals are my own and that the therapist will assist only in facilitating clarity regarding those decisions.

10. I understand that I may call my therapist between regularly scheduled sessions and that she will do her best to return my call within 24 hours. I understand that my therapist may charge me for any phone conversations that run longer than 15 minutes. I understand that my therapist is not an emergency resource and that, if I find myself having a life-threatening emergency, I should immediately call 911.

11. I understand that I have the right to terminate therapy at any time and that it is customary/advisable to discuss the termination of the therapeutic relationship to ensure proper closure. I understand that my therapist has the right to terminate therapy (with adequate notice and referrals) in the following cases: A) If I am unable to pay the fees and a mutually agreeable financial arrangement cannot be made, B) if she feels that my mental health needs can be better served by another therapist, C) if I am unable or unwilling to comply with my responsibilities that allow therapy to be effective, such as attending sessions on a regular basis and otherwise acting responsibly and in good faith, and D) if she discontinues providing psychotherapy services (i.e., moves out of the area, becomes disabled, or otherwise is unable to provide psychotherapy services).

12. I understand that all information disclosed during the session is by law strictly confidential with the following specific exceptions: by law suspected child abuse, dependent adult abuse, and elder abuse must be reported to the appropriate authorities; records may be subpoenaed in such cases where the client has introduced his/her mental status as evidence in court proceedings; if specific, physical harm is threatened by client to another person and the threat is, by reasonable assessment, deemed to be serious and imminent; or if the therapist is ordered to turn over the client's records under the provisions of the Patriot Act.

13. I understand that confidential information discussed during the session can be disclosed to third parties in certain specific circumstances: when a client is determined to be a danger to himself, to others, or to property or when a client has been determined to be gravely disabled; to health care providers for the purpose of diagnosis or treatment of patients in emergency situations and to health care service plans for the purpose of payment; to probate court investigator, probation officer, or domestic relations investigator when determining the need for guardianship; during legal proceedings prompted by an alleged breach of duty on the part of the client or the therapist; or when a client has signed an authorization to release confidential information.

14. I understand that there can be significant consequences if I release my therapeutic records to a third party and so I agree to discuss any potential release with my therapist before I authorize that release.

15. I understand that electronic communications such as email and text between therapist and client will be limited to scheduling and other logistical concerns, and not to conduct therapy or share clinical or personal health information.

16. I consent to the use of telehealth/telephone services when in-person services are not available.

Signature of Client

Date