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**Informed Consent Form**

**Confidentiality** All information between counselor and patient is held strictly confidential unless:

1. The client authorizes release of information with his or her signature via release form.

2. The client presents a physical danger to self or others.

3. Child or Elder Abuse or Neglect is suspected.

**I (Patient Name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ “Patient” confirm that I understand (In cases 2 to 3, Daniel Acosta is required by law to inform potential victims and legal authorities.)**

**Financial Terms** The hourly therapy fee is $125 for Individual and Couples Therapy and $125 for Family Therapy. Full payment is due at each session. Daniel Acosta does not accept insurance; payment is the responsibility of the client. Only credit cards are currently accepted. P**lease fill out the credit card authorization form.**

**Canceled/Missed Appointments** A scheduled appointment means that time is reserved only for you. **If an appointment is missed or canceled with less than 24 hours notice, the client will be billed according to the fee schedule listed above.** Missed appointments are the responsibility of the client.

**Sessions are 50 minutes in length unless otherwise scheduled.** Duration and frequency of services may vary depending on the nature of the problem and client’s individual needs. You have the right to end therapy at any time. If you wish, I will give you referrals for other qualified psychotherapists.

**Client Progress Assessment**: Daniel Acosta, M.A., AMFT #93817 reserves the right to make periodic assessment(s) **(after the initial session and roughly every 6 sessions thereafter)** to track client(s) progress including: poor responsiveness or resistance to clinical treatment, lack of adherence to treatment plan or to avoid an ethical conflict or problem. If at any time Daniel Acosta, M.A., AMFT #93817 determines the client(s) is not responding favorably to said treatment he will document and discuss/collaborate with the client(s) to determine a course of action which can include next steps, recommitment plan to treatment, termination of services, and/or a referral list for other clinicians the client can pursue treatment with in accordance with the CAMFT Code of Ethics 1.3.1 Termination, 1.3.2 Abandonment, and 1.3.3 Financial Gain in reference to client welfare.

**What to Expect** (Benefits and Risks) There are risks in seeking individual, marital, or family therapy. Some of the potential benefits of therapy include developing your ability to handle or cope with your relationships and providing you with greater insight into your personal goals and values. In working to achieve to achieve these benefits, however, you may address issues or make changes that you experience as distressing. These risks of therapy include, but are not limited to: feelings or circumstances becoming worse before they get better; changes in your emotional state, such as feelings of depression or anxiety; the possibility of hallucinations or disassociations; changes in perception or behavior; and changes in occupational, social, or personal relationships.

**Consent for Treatment**

I authorize and request that Daniel Acosta, M.A., AMFT #93817, employed and under the supervision of Dr. Heather Coakley, Psy.D., PSY20178 provide psychological examinations, treatments, and/or diagnostic procedures which now or during the course of my care as a client are advisable. I have read and understood the preceding statements. I have had the opportunity to ask questions about them, and I agree to enter a professional psychotherapy relationship between Daniel Acosta, AMFT and myself or my child. **I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable**.

**Confirmation of Receipt of “California Association of Marriage and Family Therapists Code of Ethics” Pamphlet** I (Patient Name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ “Patient” confirm that I have received, reviewed, read, and understood the “California Association of Marriage and Family TherapistsCode of Ethics” Pamphlet via Daniel Acosta’s website at: <https://www.therapysolutionstoday.com/forms>

**Confirmation of Receipt of “Professional Therapy Never Includes Sex” Pamphlet**

I (Patient Name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ “Patient” confirm that I have received, reviewed, read, and understood the “Professional Therapy Never Includes Sex” Pamphlet via Daniel Acosta’s website at: <https://www.therapysolutionstoday.com/forms>

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Signature of Client (or parent/guardian)/Date

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Signature of Therapist/Date