26932 Oso Parkway, Suite 200
Mission Viejo, CA 92691
Phone: 949-763-3059
Email: Connect@DrAmberBaker.com
Website: www.DrAmberBaker.com
CA License # PSY 24533

Informed Consent for Treatment

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

SERVICE PROVIDER:
Amber Baker, Ph.D.
Licensed Clinical Psychologist

EDUCATION/DEGREES/TRAINING:
- Doctorate in Counseling, Clinical, and School Psychology – Clinical Emphasis, 2010
  University of California, Santa Barbara
- Masters of Arts in Counseling Psychology, 2006
  University of California, Santa Barbara
- Bachelor of Arts in General Psychology, 2004
  University Honors Program Graduate
  California State University, Long Beach
- Postdoctoral Fellowship, completed 2011
  Long Beach Veterans Administration, PTSD Specialty Clinic
- Predoctoral Internship, completed 2010
  Los Angeles Ambulatory Care Center
- Child Abuse Listening Mediation (CALM), completed 2007
  Externship; Registered Psychological Assistant

REGISTRATION:
Licensed Clinical Psychologist
California Board of Psychology – License # PSY24533

PSYCHOLOGICAL SERVICES
I am a licensed Psychologist in the state of California. I provide individual, couples, and family therapy and consultative services. Areas of specialization include: anxiety, trauma/PTSD, and relationship issues. Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you hope to address. There are many different methods I may use to deal with those problems. You are entitled to receive information regarding your treatment plan, such as methods of therapy, the techniques used, and duration (if known).

Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees as to what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

Therapy involves a commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, then I will be happy to help you set up a meeting with another mental health professional for a second opinion. You have the right to terminate therapy at any time, although I recommend doing so only after discussing your concerns with me directly.

A decision on my part for early or premature termination of our professional relationship would be for one of the following reasons: it is reasonably clear that you no longer need, are not benefitting from, or are being harmed by treatment, or if you or someone in a relationship with you threatens or endangers me, if you are in need of services that I am not able to provide, financial non-cooperation, or any other needs of mine. Should we prematurely end our professional relationship, you will be provided with appropriate referrals and recommendations about how to proceed unless your actions make it impossible, such as refusing to attend therapy sessions.

MEETINGS AND CANCELLATION

I normally conduct an evaluation that will last from one to four sessions. During this time, we can decide together if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session per week at a time we agree on, although some sessions may be longer or more frequent, such as 90 minute appointments, or longer, for couples. Scheduling an appointment involves the reservation of time specifically for you. Once an appointment hour is scheduled, you will be expected to pay the standard fee for it unless you provide 24 hours advance notice of cancellation. If you are late for a session, I am not required to extend the appointment to make up for lost time, and if you have not called ahead, I may not wait more than 25 minutes.

I understand that I must cancel sessions 24 hours in advance or I will be billed for the scheduled hours.

_____ *initial(s)*

PROFESSIONAL FEES

My 50-minute clinical hour fee is $180. Ninety-minute sessions are $320. Therapeutic sessions or services provided that last more than the usual time will be charged accordingly. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you leave more than 10 minutes worth of phone messages in a week, or if I spend more than 10 minutes reading and responding to emails from you during a given week, I will bill you on a prorated basis for that time. My fees go up $10.00 every two years, on the even year. If a fee raise is approaching I will remind you of this well in advance.

I understand that psychotherapy and all related services are billed at $180 per clinical hour, $320 per 90 minutes, and additional time is billed at a prorated rate.

_____ *initial(s)*

Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement the party responsible for my participation agrees to reimburse me at the rate of $520 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

I understand that Dr. Baker's hourly fee for work related to any legal matter is $520 per hour and additional time is billed at a prorated rate.

_____ *initial(s)*

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. Payment schedules for other professional services will be agreed to when they are requested. Fees are collected at each visit for the hours performed that day. *Having your cash or check ready at the beginning of each session is avoids wasting therapy time.*

There will be a returned check fee of $25.00 should there be any problems clearing your check. If for any reason you do not pay your bill at the time of service, a $50.00 late fee will be assessed for each 30 days that you do not pay. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the dates, times and nature of services provided, and the amount due.

Payment must be made in the form of cash or check. Please make all checks out to: **Amber Baker, Ph.D.**

I understand that I am responsible for paying at the time of each visit.

_____*initial(s)*

INSURANCE

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. This practice does not accept medical or mental health insurance and will not bill your services directly to your insurance carrier. If you have a health insurance policy, however, it may provide some coverage or reimbursement for mental health treatment. I will provide you with whatever assistance I can in helping you receive reimbursement for the services you have paid for, such as providing insurance ready statements periodically detailing any direct payments you have made to the practice. These statements may be used to initiate the reimbursement process privately through your insurance company if you choose. You (not your insurance company) are responsible for full payment of my fees, as outlined above. It is very important that you find out exactly what mental health services your insurance policy covers if you wish to submit a claim for reimbursement. Authorization is usually required in advance. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator.

Please note that insurance companies usually require the therapist to identify a clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). Whatever information is disclosed to your insurance company will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.

I understand that my insurance cannot be billed directly for services provided by Dr. Baker. I am responsible for full payment.

_____*initial(s)*

CONTACTING ME

I am often not immediately available by telephone. Though I am in the office several days a week I will probably not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail. I will check messages several times during the week but may not do so daily. If you are difficult to reach, please inform me of some times when you will be available. In most cases I will return your call within 24 hours with the exception of holidays. However, I cannot guarantee a phone response within a certain period of time. If you are unable to reach me and feel that you cannot wait for

me to return your call, contact your family physician, or the nearest emergency room and ask for the psychologist [psychiatrist] on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email or text me about clinical matters because email and text are not secure ways to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Emergencies: Please be aware that **I do not provide emergency services** or wear a pager and am not "on call." If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician, 911, or the nearest emergency room and ask for the psychologist or psychiatrist on call.

I understand that Dr. Baker does not provide emergency services. In an emergency situation, I know to call 911 or go to the nearest hospital emergency room.

_____*initial(s)*

PROFESSIONAL RECORDS

You have specific rights with regard to your clinical record. Your file will remain active while you are participating in treatment. *When our work concludes, or it has been at least 30 days since our last contact, your file will be closed.* You may request amendments to your record, request to restrict the information disclosed to others, request an accounting of disclosures, and determine the location to which protected health information is sent (please see my Notice of Privacy Practices for more information). The laws and standards of my profession require that I keep treatment records. Except in specific circumstances, you are entitled to examine your clinical record and/or receive a copy at a rate of ¢25 per page. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. In the event that you do review the full records I recommend that they are reviewed in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests. You may request that any complaints you have about my privacy policies and procedures be recorded in your records.

I understand my rights pertaining to my clinical records, and that my file will be closed at the conclusion of our work together or 30 days after our last contact.

_____*initial(s)*

CONFIDENTIALITY [for adult patients]

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused or has been abused, I may be required to make a report to the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include, among others, notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs in the course of our work together, then I will make attempt to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I feel that it is important to our work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney. Please see my Notice of Privacy Practices for more detailed information regarding confidentiality.

I understand that my mental health information will be kept confidential unless my psychologist believes that I may harm myself, her self, or someone else, if I disclose that a child, elderly person, or disabled person is being mistreated, if a judge orders it, or If disclosure is otherwise specifically required by federal, state, or local laws.

_____*initial(s)*

COUPLES

This is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in couples therapy with me. If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. Do not tell me anything you wish kept secret from your partner. I will remind you of this policy before beginning such individual sessions.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signature of Client:

_____

Printed Name: _____ Date: ____/____/ ____

Signature of Client:

_____

Printed Name: _____ Date: ____/____/ ____

Signature of Personal Representative (if other than client):

_____

Printed Name: _____ Date: ____/____/ ____

MINORS

Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with Me

In the course of my treatment of your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child – not the parents/guardians, nor any siblings or other family members of the child.
If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm and the police.
- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am may be required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

> ***Example***: If your child tells me that he/she has tried alcohol at a few parties, I would keep this information confidential. If you child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.
>
> ***Example***: If your child tells me that he/she is having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing _____, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I try and help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents

Although the laws of California may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements. Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to

any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $520 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Child/Adolescent Patient:

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor's Signature* _____ Date_____

Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. _____ _____

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment. _____ _____

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above. _____ _____

Parent/Guardian Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

* For very young children, the child's signature is not necessary

PLEASE NOTE

Dr. Baker is an independent practitioner and is not formally associated with any group or other practitioner. Sharing office space, forms, or expenses with other clinicians does not imply any professional involvement with other practitioners, and they are not responsible in any way for actions Dr. Baker may take. Likewise, Dr. Baker is not responsible for any actions taken by colleagues sharing office space, forms or expenses.

NOTICE: The California Board of Psychology regulates the practice of Psychology in the state of California. Concerns or complaints regarding the practice of psychotherapy may be directed to the California Board of Psychology. The contact information is: 2005 Evergreen Street, Suite 1400, Sacramento, CA 95815-3831 bopmail@dca.gov
Toll Free Number: 1-866-503-3221.