ANXIETY THERAPY LA

TREATMENT AGREEMENT

Name: _____ **Date:** _____/_____/_____

Address: _____

City: _____ **Zip:** _____

Phone (H): _____ (W): _____ (C): _____

Birth date: _____ /_____ /_____ **Email:** _____

Referred By: _____ **Phone :-** _____

Emergency Contact (Name): _____

Phone: _____ **Relationship:** _____

Physician: _____ **Phone:** _____

Last examination date: _____/_____/_____

Psychiatrist: _____ **Phone:** _____

Are you taking any medication or experiencing any health problems? **Y/N** (circle one)
If yes, please list:

Name:	Dose:	Date 1st taken:	Reason:

Insurance Information:
Do you currently have insurance coverage? Y/N (circle one)

Do you have Mental Health Coverage under this policy? Y/N (circle one)

Name of Insurance Co: _____ **Effective Date:** _____/_____/_____

Plan Type: PPO or HMO (circle one) **Ph:** _____

Policy Holder: _____ **Address: -** _____

Policy #: _____ **Group #:** _____

This document contains important information about the professional services and business practices of Samira Soroory, Licensed Marriage & Family Therapist (MFT 105808) at Anxiety Therapy LA. Anxiety Therapy LA is a DBA for Michelle Massi, A Family Counseling Corporation. 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.

Psychological Services: I am currently licensed as a Marriage & Family Therapist (MFT 105808). At an appropriate time, I will discuss my professional background with you and provide you with information regarding my experience, education, special interests, and professional orientation. You are free to ask questions at any time about my background, experience and professional orientation.

Assessment & Treatment: Our initial sessions will involve an assessment of your needs. Typically, this evaluation will last from 2-4 sessions. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include. During this time, we can both decide if I am the best person to provide the services that you need in order to meet your treatment goals. Treatment can be time consuming and stressful. Since therapy often involves discussing unpleasant aspects of your 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 of what you will experience.

You are entitled to ask questions about all aspects of treatment. If you have questions about my procedures, we should discuss them whenever they arise. I will be happy to help you secure a consultation with another mental health professional whenever you request it or I recommend it.

The Client's Role: You are expected to play an active role in your treatment, including working with me to outline treatment goals and completing questionnaires at the beginning of treatment and periodically during treatment to assess progress. You will be asked to complete homework assignments between sessions and your willingness to do this can be an integral part of a successful treatment. If at any point you are unhappy about the progress, process, or outcome of the treatment, please discuss this with me and I will attempt to resolve any difficulties that have arisen and to arrive at a treatment plan that better meets your needs.

The Client's Rights: A document entitled "Patient's Bill of Rights," adapted from a publication by the California Department of Consumer Affairs, is attached. Please raise with me any questions you might have.

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration of your treatment goals. You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan or terminating your therapy.

Meetings: Therapy sessions are usually scheduled as 50 -minute sessions once a week, or as your treatment needs dictate and we agree. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24-business hours advance notice of cancellation** (unless we both agree that you were unable to attend due to circumstances beyond your control). For Monday appointments you must cancel by Friday. **It is important to note that insurance companies do not provide reimbursement for cancelled sessions; therefore you will be responsible for payment for the missed session.**

Professional Fees & Payment: You will be informed of the fee for services no later than the end of the first appointment. You agree to provide payment for services, either in the form of a personal check or cash, at the end of each session and to reimburse me for any and all bank fees for returned checks. My usual and customary fee for service is **$165.00** per 50 minute session. Longer or shorter sessions are generally pro-rated from this base fee. Client will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by agreement with Therapist. Therapist reserves the right to periodically adjust the fee. Payment is due at the time of the session unless another arrangement has been made. Payment schedules for other professional services (eg: report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, and preparation of records or treatment summaries) will be agreed to when they are requested. All payments should be made to Anxiety Therapy L.A.

Insurance Reimbursement: If you have insurance and elect to seek reimbursement for your treatment please let me know this by the end of the first session. Even if you do choose to use your insurance, it is my policy that you pay me for the *full balance* of

the fees for services rendered up front. Any amount covered by the insurance company will be reimbursed directly to you. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. I am unable to guarantee whether your insurance will provide payment for the services provided to you.

When you seek reimbursement most insurance companies require that I release any and all pertinent information regarding your treatment, including but not limited to, diagnosis, treatment plan, treatment progress, number of sessions attended, social security number (for identification purposes), and medications you have taken. In addition, you must be aware that once information is released to the insurance company, I cannot guarantee that it will remain confidential. Before I send any information to an insurance company, I will discuss with you the information to be disclosed and will obtain your written permission to release the information to your provider.

Confidentiality: In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information about our work to others with your written authorization. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. **However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family. However, there are a few exceptions to confidentiality:

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

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, an elderly person, or a disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include 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, I will make every effort to fully discuss it with you before taking any action.

In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the item under the Act.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, 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 if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. [If you request, I will provide you with relevant portions or summaries of the state laws regarding these issues.]

Minors and Confidentiality:
Communication between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently in the exercise of my professional judgment, I may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns they have on this topic with me.

Professional Records:
The laws and standards of my profession require that I keep treatment records. The information in the chart includes demographic information, a description of your condition, your treatment goals, your treatment plan and progress in treatment, dates and fees for sessions and notes describing each therapy session.

Because these records contain information that can be misunderstood by someone who is not a mental health professional, it is my general policy that patients may not review them; however, I will provide at your request a treatment summary unless I believe that to do so would be emotionally damaging. If that is the case, I will be happy to send the summary to another mental health professional who is working with you. Patients will be charged an appropriate fee for any professional time spent in preparing and responding to information requests.

Contacting Me: Telephone consultations between office visits are welcome. However, I will attempt to keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions. You may leave a message at any time on my confidential voicemail at (**424) 248-8328**. If you wish me to return your call, please be sure to leave your name and phone number(s) along with a brief message concerning the nature of your call. Non-urgent calls are returned during normal workdays (Monday through Friday) within 24 hours. If you have urgent need to speak with me, please indicate that fact in your message and follow any instructions that are provided in the voicemail. **In the event of an emergency or imminent danger** please call 911. For all other urgent matters or clinical emergencies, you can reach me by text messaging me at (424) 248-8328 and typing in your telephone number (or number where I can reach you). If I do not call you back within one hour, please place the text again.

From time-to-time, I may engage in telephone contact with a client for purposes other than scheduling sessions. Client is responsible for payment of the agreed upon fee (on a pro-rated basis) for any telephone call longer than ten minutes. In addition, from time-to-time, I may engage in telephone contact with third parties at client's request and with client's advance written authorization. Client is responsible for payment of the agreed upon fee (on a pro-rated basis) for any telephone calls longer than ten minutes.

If I am out of town or unavailable via phone or text for any reason I will provide coverage by a colleague and an announcement of such coverage will be made on the outgoing message of my voicemail system. I agree to take all reasonable precautions to ensure that all voicemail messages are returned within 24 hours and that all emergency pages are returned as soon as possible. Please note, however, that no voicemail/pager system is 100% foolproof, and technical problems may occur. In the event an emergency page is not returned in a timely fashion, please send another page to me. In the unlikely event that you are experiencing a clinical emergency I have not responded, please call 911 for assistance.

In regard to emails, I requests that you only send emails regarding non-urgent matters that we have previously discussed, since several days may pass before the email is retrieved and since some emails are returned undeliverable. In addition, you should never send via email any information that you would like to be kept confidential. As is true of any email, confidentiality can never be guaranteed. For all urgent or emergent matters and for any communication of confidential information, please use only telephone and voicemail.

Acknowledgment
Please do not sign if you have any questions regarding the contents of this letter or if any of the information is unclear. Thank you.

"By signing below, I acknowledge that I have read and understand the information presented in this five page Treatment Agreement letter and that I give my consent for treatment to Samira Soroory, Licensed Marriage & Family Therapist, (MFT 105808). This consent shall remain in effect for the duration of my therapy or until I provide written revocation of my consent to Samira Soroory. I further acknowledge that I have received a copy of this letter for my own records."

_____
Client name

_____ _____ /_____ /_____
Signature of client/parent/guardian/conservator Date

_____
If signed by someone other than client indicate relationship

Samira Soroory. LMFT
Therapist name

_____ _____ /_____ /_____
Therapist Signature Date

PATIENT BILL OF RIGHTS

You have the right to:

*Request and receive information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.

*Verify licensure of the therapist with the Board of Behavioral Sciences and receive information about any license discipline. You can do this on the Board's website at www.bbs.ca.gov. Click on "License Verification."

*Have written information about fees, methods of payment, insurance reimbursement, number of sessions, length of sessions, professional assistance when your therapist is not available (in cases of vacation and emergencies), and cancellation policies before beginning therapy. This kind of information is referred to as informed consent.

*Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.

*Receive a verbal or written treatment plan.

*Have a safe environment, free from sexual, physical or emotional abuse.

*Expect that your therapist should not involve you in any social or business relationship that conflicts with your therapy relationship.

*Ask questions about your therapy or psychological assessment.

*Refuse to answer any question or disclose any information you choose not to reveal.

*Request that the psychologist inform you of your progress.

*Know if there are supervisors, consultants, students, registered psychological assistants or others with whom your therapist will discuss your case.

*Refuse a particular type of treatment or end treatment at any time without obligation or harassment.

*Refuse or request electronic recording of your sessions.

PATIENT BILL OF RIGHTS

*Request and (in most cases) receive a summary of your records, including the diagnosis, treatment plan, your progress, and type of treatment.

*Report unprofessional behavior by a therapist.

*Receive a second opinion at any time about your therapy or about your therapist's methods.

*Receive referral names, addresses and telephone numbers in the event that your therapy needs to be transferred to someone else and to request that a copy or a summary of your records be sent to any therapist or agency you choose.

What Does HIPAA Mean To You
An Introduction to Privacy Rights for Clients

You may have heard about the complex federal privacy rule under the Health Insurance Portability and Accountability Act, better known as HIPAA. It is important that, as a client, you understand what this rule means, and how it could affect you.

In general, HIPAA establishes requirements for how your therapist -- as well as other health care professionals and organizations -- use and disclose your records. HIPAA also provides certain basic privacy rights and helps clarify all patient privacy rights, including those that exist under state law.

Following is a brief summary of the HIPAA rule. Attached you will also find a detailed notice of your privacy rights, which is a requirement of HIPAA.

Under the HIPAA rules:

- I will exercise even greater care in handling your records to prevent unauthorized individuals from seeing them.

- You generally have the right to review your records, receive a copy of them, and request that any errors be corrected. In certain situations, I have the right to deny such requests.

- You have increased protection from insurance companies and others who may ask to see your records.

- You are able to request certain restrictions on the disclosure of your records – although I may use my best judgment about whether to comply with your request.

- You have the right to receive confidential communications of health information at any location you specify. For example, a client may request that a bill be sent to an address other than his or her home, or ask me not to leave any messages on a home answering machine.

Be assured that Samira Soroory, Licensed Marriage & Family Therapist considers maintaining my clients' privacy a critical component of my practice. The Notice of Private Practices attached to this letter explains our privacy practices in greater detail, which is a requirement of HIPAA.

16055 Ventura Blvd., Suite 1020 • Encino, CA 91436 • 310.592.0597

Please let me know if you have any questions about the Notice of Privacy Practices. You may contact our Privacy Officer Michelle Massi, LMFT at: *2001 S. Barrington Ave Ste 308, Los Angeles 90025, voice (310) 592-0597,* or discuss any questions you may have with your therapist.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (name of patient), have received a copy of Anxiety Therapy LA Notice Of Privacy Practices.

_____ _____

Signature of client/parent/guardian/conservator Date

_____

If signed by other than client indicate relationship

NOTICE OF PRIVACY PRACTICES
Of the Private Practice of
Anxiety Therapy LA, INC

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Samira Soroory is a licensed Marriage & Family Therapist (MFC 105808) in the State of California through the Board of Psychology. I work as an independent clinician. I create and maintain treatment records that contain individually identifiable health information about my clients. These records are generally referred to as medical records or mental health records, and this notice, concerns the privacy and confidentiality of those records and the information contained therein.

I am required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office and on my website.

Except for specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation. And, I am legally required to follow the privacy practices described in this Notice.

Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment or Health Care Operations Do Not Require Your Written Consent. I can use and disclose your PHI without your Authorization for the following reasons:

1. **For your treatment.** I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.
2. **To obtain payment for your treatment.** I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for

the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.

3. **For health care operations.** I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require Your Authorization

1. **Psychotherapy Notes.** I do not keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501; rather, I keep a record of your treatment and you may request a copy of such record at any time, or you may request that I prepare a summary of your treatment. There may be reasonable, cost-based fees involved with copying the record or preparing the summary.
2. **Marketing purposes.** As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. **Sale of PHI.** As a psychotherapist, I will not sell your PHI in the regular course of my business.

Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations mandated by law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting

intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

Certain Uses and Disclosures Require You to Have the Opportunity to Object

1. **Disclosures to family, friends, or others.** I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights with respect to your PHI

1. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You ask me not to use or disclose certain PHI for treatment, payment or health care operation purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. **The Right to Choose How I Send PHI to You.** You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. **The Right to See and Get Copies of Your PHI.** Other than "psychotherapy notes," you have a right to get an electronic or paper copy of your medical record and other information that I have about you.
   I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. **The Right to Get a List of the Disclosures I Have Made.** You have a right to request a list of instances in which I have disclosed your PHI for purposes

other than treatment, payment, or health care operations, or for which you provided me with an Authorization.
I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. **The Right to Get a Paper or Electronic Copy of this Notice.** You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by email. And, even if you have agreed to receive this Notice via email, you also have the right to request a paper copy of it.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officers for my practice, and my address and telephone are:
Michelle Massi, LMFT,
2001 S. Barrington Ave, Ste 308
Los Angeles, CA 90025
(310) 592-0597

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;
2. Calling 1-877-696-6775; or
3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints

I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on September 20, 2013

CONSENT FOR EMAIL/TEXT MESSAGE COMMUNICATION

I, _____ (name of patient) understand that the confidentiality of communication through e-mail/text message exchange cannot be guaranteed. I also understand that if my therapist is informed only via e-mail/text message, she is making judgments on the basis of limited and imperfect information. I understand that if I choose to correspond with my therapist through e-mail/text message, she will make every effort to keep the information she received confidential, but that my therapist cannot guarantee the confidentiality of e-mail/text message communications. If I communicate with my therapist via e-mail/text message, I agree to accept the risk that a breach of confidentiality may occur. I also understand that e-mail is not a means for emergency contact and my therapist cannot guarantee prompt response.

_____

Client name

_____ _____ /_____ /_____

Signature of client/parent/guardian/conservator Date

_____

If signed by someone other than client indicate relationship

Samira Soroory, LMFT _____

Therapist name

_____ _____ /_____ /_____

Therapist Signature Date

16055 Ventura Blvd., Suite 1020 • Encino, CA 91436 • 310.592.0597

TELEMEDICINE INFORMED CONSENT

I, _____ (name of patient) hereby consent to engaging in telemedicine with Samira Soroory (MFT 105808) as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with

any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

_____

Client name

_____ _____ /_____ /_____

Signature of client/parent/guardian/conservator Date

_____

If signed by someone other than client indicate relationship

Samira Soroory, LMFT

Therapist name

_____ _____ /_____ /_____

Therapist Signature Date