Informed Consent for Initial Assessment Consultation

Name: _____ DOB:_____

Address: Street:_____ City: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____

Referred by: _____

The purpose of initial assessment consultation(s) is to determine your needs and to help you decide what form(s) of consultation may be desirable. Any other services such as psychotherapy or counseling are offered under a separate service agreement.

Reason for seeking this consultation:

_____

_____

FEES

California law requires that you be made aware of fees before we begin. The standard fee is $140.00 per (50) minutes for this initial consultation under this agreement, payable at the time of service by check or cash. If you decide to begin psychotherapy the standard is $140.00 per (50) minutes.

YOUR AGREEMENT TO ARBITRATION

I agree to submit any disagreement concerning services or complaints regarding breaches in law or ethics, to binding arbitration under the auspices of the American Arbitration Association. I agree to pay any and all legal costs arising from complaints that are not fully validated by the arbitrator. I also agree to pay any other legal fees incurred by the therapist as a result of these sessions.

CONFIDENTIALITY

I understand that in some instances my confidentiality is limited by law and is compromised by all forms of electronic communication.

Release of Confidential Information

Are you currently in therapy? _____ Yes _____ No

If so, who is your current therapist?

1. Name: _____Phone: _____

   Address_____

Who are your past therapists? Who is your current psychiatrist?

2. Name: _____Phone: _____

   Address_____

3. Name: _____Phone: _____

   Address_____

Note: Professional ethics require that therapists obtain pertinent records from current and previous therapists and physicians in order to work effectively with you. Should you decide to continue services beyond a few consultations/assessment sessions, an 'Informed Consent for Treatment' form will be provided and must be agreed to beforehand.

I hereby give permission to the above named therapists and/or physicians to release their confidential records of my treatment to:

Therapist's Name: Jim Swaniger, MA, LMFT
Therapist's Voicemail: (949) 760-7171

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date

PLEASE NOTE:

THE PROFESSIONALS WHO SHARE THIS SUITE ARE INDEPENDENT AND SOLE PRACTIONERS AND NOT PART OF A GROUP.