**Christian Alzubi, MS, LMFT**

**License #107617**

**650-590-5453**

**Email:** [**Christianalzubilmft@gmail.com**](mailto:Christianalzubilmft@gmail.com)

**INFORMED CONSENT CONTRACT**

**FOR TELECARE SERVICES**

Welcome to my practice. This documents contains important information about my professional services and business policies and how they may affect you. Please read carefully and make note of any questions you want to discuss with me. Once you sign this document it will become a binding agreement between us and also provide your consent for us to begin therapy.

Therapy is a unique and highly individual experience with the outcome determined by the effort and motivation you bring to work towards a change in yourself and how you see the world around you. It can result in a number of benefits to you and can potentially help in your ability to detect, challenges and change beliefs and attitudes that create, maintain, and worsen feelings of depression, anxiety, panic, anger, frustration, etc. Therapy also has the potential to help you gain new or deeper understanding about your issues and learn new ways of coping with and solving them.

However, there is no guarantee that therapy will yield positive or intended results. Because feelings will be explored, you may feel a range of emotions that can be intense and uncomfortable at times. During the course of therapy some of you assumptions, perceptions, or behaviors may be challenged, which can cause you to feel upset, angry, depressed, uncomfortable, confused, or disappointed. I encourage you to explore those feelings during our sessions, as they are part of the therapeutic process. In the attempt to resolve issues that originally brought you to therapy, unintended changes in your personal and interpersonal relationships my result.

Our therapeutic relationship is strictly voluntary. At any time during our work together, you have the right to decide to end treatment. If you are thinking about ending therapy, I encourage you to discuss it with me, and if you wish I will be glad to provide you with appropriate referrals and assist you in the transition to a new therapist

**Sessions**

Each session is 50 minutes and will begin at the time agreed. If you arrive late to the appointment, I will end the session at the allotted time.

**Cancellation and Rescheduling**

If you need to cancel or reschedule a session, please notify me by telephone or email at least 24 hours in advance of our scheduled session.

**Fee and Payment**

Your session fee is will be agreed upon on by therapist and client. Payment of this fee needs to be made at the beginning of each session in full unless other arrangements have been made. Please bring a check ready (made payable to Christian Alzubi, LMFT) or credit card, so that we can maximize your therapy time. Your session fee may be increased annually. In the event of any fee changes, you will be notified at least 30 days prior to such change.

**Additional Fees**

Extended sessions and telephone conversations that exceed ten minutes will be charged a fee based on your regular session fee. Written reports, evaluations authorization or requested by you or copying your file follow the same policy.

**Contacting me**

You may contact me at 650-590-5453 Monday through Sunday until 8pm. I will try my best to reach you within 24hours of your phone call. I will only return calls in the cases of emergency. Phone calls are generally limited to 10 minutes beyond this time you will be charged at a prorated amount of my usual fee.

**Email Usage**

**Therapy is confidential**. You can be confidence that your insights, vulnerable experiences, and feelings will not be repeated outside the therapeutic relationship establish.

**Email correspondence is NOT confidential.** Though internet security measure can be effective, it is never 100%.

My policy regarding email usage is as follows.

* Email correspondence with me is NOT secure
* Email correspondence is NOT a substitute for person-to-person therapeutic treatment, unless discussed with me in advance and in person.
* Email correspondence will not play a part in your therapy.
* I will not respond to your emails in general. Anything stated in an email from you will be discussed in session, and in session only.
* Email correspondence is NOT to be used in the case of an emergency to contact me.
* If you need to contact me with something that demands immediate attention, you will do so voicemail at the following number **650-590-5453, call 911 or go to the emergency room.**
* If it becomes necessary, I will terminate treatment if email usage is or become inappropriate.

**Emergencies**

If you are experiencing a life-threatening emergency and need to talk to someone immediately call 911, the Suicide Prevention Hotline at (800) 273- TALK (8255), the police or your local emergency room and ask for the psychologist or psychiatrist on call.

**Confidentiality**

Everything you say and share is session is strictly confidential. However, there are some exceptions to the rule of confidentiality.

I am required by law to report:

* Threats of harm to another or oneself
* Suspected child or elder abuse (past or present)
* By court order

Other exceptions include:

* Per your signed release
* I may discuss your case with peers in order to provide excellent services. In doing so, I will keep your identity or any details allowing your identification confidential.

With minors, confidentiality will be kept unless there is concern that the child is in danger to themselves, someone else, or has been harmed. In these cases the parent(s) will be notified of the concern and if possibly, I will have discussed the matter with the minor and have done my best to handle any objections he/she may have. During treatment, I will provide parents with only general information about the progress of treatment and the attendance of scheduled sessions.

**Agreement**

I have read this information fully and completely, I have discussed any questions I had about the information, and I understand the information. I acknowledge that it is my choice to participate in my psychotherapy (or have my child participate). I realize that the outcome of therapy depends upon my personal investment in the therapy process. I have familiarized myself with the fees for charges provided by Christian Alzubi M.S., LMFT, and I understand and agree that the therapeutic services rendered will be charged to me and not to any third-party payer. I acknowledge responsibility for payment of these services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client (Parent) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client (Parent) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Child Date

Christian Alzubi, LMFT 05/21/2020

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Therapist Date