JUDITH ZUCKER ANDERSON, PH.D.
CLINICAL PSYCHOLOGIST
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Telephone 949-727-4337 Fax 949-494-0865

I look forward to helping you with the concerns and difficulties you would like to explore and resolve. There are some policies and procedures that I may neglect to fully review with you initially because I am most interested in understanding you and your concerns. As a consumer of psychological services you are entitled to be fully informed. Please feel free to discuss any questions or concerns you have about these policies or any other matters at any time.

My view of psychotherapy is that you, as a client, are hiring me, as the therapist, to consult with you regarding growth issues or problems that significantly affect you life. The goals of therapy should be set by both client and therapist, so that our agendas in working together can be clear and most effective. With these mutually agreed goals in mind, a treatment plan will be developed for you using the latest psychological information available.

The following statements are to provide you with information concerning therapy, as well as the legal and ethical issues related to services provided by licensed psychologists in California.

Confidentiality

The information presented in therapy is personal and confidential. The only circumstances in which information could be shared without your prior written and verbal permission are when there is a clear intention to do harm to yourself or to someone else, when your insurance company asks for routine information previously authorized or when a valid court subpoena is received. I also have a legal and ethical responsibility to notify appropriate social agencies of any suspicion of emotional, physical or sexual abuse or neglect of a child, a disabled person, or an elderly person. Please note that if you initiate a lawsuit, your mental status may become subject to court scrutiny. If the lawsuit involves your mental condition, you generally waive your confidentiality rights.

Confidentiality in couple or family therapy: When I treat you as part of a couple or family group, no information is released to outside parties without the written consent of all parties present. Minor children will also be asked for their consent. When we meet in individual sessions in the context of family therapy, no information is shared with other members of the family unless the individual (even though he/she may be a minor child) shares it himself/herself or indicates a willingness to share.

Fee for Services

Payment is to be made in full with cash or a personal check at the time of the session. If you have insurance coverage we will be glad to provide you with a receipt or statement satisfactory for filing your insurance claim. My office will be glad to assist you in determining the extent and limitations of your coverage.

Therapy is a significant personal and financial commitment. Please do not hesitate to discuss any concerns you have with me.

If you have difficulty paying for therapy under the conditions outlined here, then you and I should discuss alternate plans. If payment is neglected, I reserve the right to terminate therapy until the balance is met. Such a termination will be discussed in depth with you before it goes into effect. If it is necessary to use collection procedures, interest will be charged at the rate of 1.5% per month (18% annually) beginning 30 days after the charge is incurred.

Third-Party Payers

Insurance companies, health maintenance organizations, and preferred provider organizations sometimes require extensive documentation of your treatment. While I am happy to comply with such requests, I must charge for my time and/or preparation as well as copying costs if lengthy documentation is required. Such organizations may not be covered by any ethical guidelines. It is my policy to contact you directly when I receive written requests even when I have written authorizations to release information. I do this so we can discuss what you wish released and how I might accomplish this. You should be aware that by using third party payment, the releases you sign and/or the processing procedures followed by invalidate some of your legal protections of confidentiality.

Missed Appointments and Cancellation

Sometimes emergencies come up. If I need to cancel or change an appointment time, I will give you as much notice as possible. I require that you will give me 24 hours notice if you must cancel the appointment. If, for any reason, you cannot let me know 24 hours in advance, you will be charged the regular fee.

Consultation with Peers

I routinely consult with my therapist peers regarding cases. This is to insure my objectivity and that I do not overlook possible avenues to help you. I do not use my clients' names and try to omit all identifying information. If you have any questions or discomfort about this, please do not hesitate to discuss this with me.

Independent Practice

While I share office space with a multidisciplinary group and enjoy the benefits and the stimulation of interaction with my very skilled peers, we each practice completely independently and are responsible for our own policies and practices.

Telephone Calls Between Sessions

Routine calls for the purpose of scheduling or billing formation are an expected part of my service and not billed. Telephone calls that are primarily therapeutic in nature and extend more than ten minutes will be prorated and billed at the usual rate.

Answering Service

Nonurgent messages should be left at my voice mail 949-727-4337. If you do not receive a call back within 12 hours of when you leave a message, please call again because we may not have gotten the message. **If your call is truly urgent or an emergency, please call our exchange at 1-800-274-2612.**

Vacation Policy

I will always inform you about my plans to be away from the office on the day(s) we usually meet. When I am not available at times other than our scheduled times, I will usually inform you in advance. In any case, my office will be available to inform you who will be on call. Your signature on this form provides me with permission to share some information about your case with the on call therapist covering for me.

I am also enclosing copies of my background and a statement of my therapy orientation and policies. A copy of your rights as a client and the ethical principles of the American Psychological Association are available in my office for you to read. I hope our work together will add significantly to your experience of well being and achieving your goals.

Signatures:

By signing below, you agree as follows:

I have read the materials presented in this disclosure statement. My signature indicates that I understand the information, and agree with the conditions of therapy that are either stated or implied here and I commit myself to compliance with them.

I understand that once therapy begins, I retain the right to withdraw consent to participate in therapy at any time that seems appropriate. I will make every effort to discuss my concerns about the progress of therapy with you before I terminate.

Client	*Date*
Client	*Date*
Judith Zucker Anderson, Ph.D.	*Date*