Anthony Zamudio, Ph.D.
Clinical Psychology
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INFORMED CONSENT FOR TREATMENT

Patient _____ , authorizes and requests psychologist, Dr. Anthony Zamudio, Ph.D., to provide psychological examinations, assessment, interventions and/or diagnostic procedures that now or during the course of treatment are advisable. The frequency and type of assessment will be decided between therapist and patient.

The purpose of these procedures and treatments will be explained and be subject to verbal agreement.

It is understood that there is an expectation that the patient will benefit from this assessment and/or interventions but there is no guarantee that this will occur.

It is understood that maximum benefit will occur with consistent attendance and that at times the patien may feel conflicted about therapy as the process can sometimes be uncomfortable.

CONFIDENTIALITY: All information disclosed within sessions, including that of minors, is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law. Disclosure may be required in the following circumstances:

- **When there is a reasonable suspicion of abuse to a child, dependent or elder adult.**
- **When there is a reasonable suspicion of knowingly downloading, streaming and accessing through electronic or digital media, materials of a child engaged in an act of obscene sexual conduct.**
- **When the client or credible third person communicates a serious threat of bodily injury to others.**
- **When the therapist has a reasonable belief that the client may be a danger to him or herself, others or property of others.**
- **When disclosure is otherwise required by law.**

I receive regular professional consultation. In such cases, neither your name or any identifying information about you is revealed.

EMERGENCY TREATMENT
If you have a life threatening emergency please call 911. I am not able to provide 24 hour availability. I usually return calls within 24 hours or the next business day. When I am out of town or otherwise unavailable, a qualified professional will cover for me by checking my telephone voicemail.

PAYMENT: Payment is due at the end of each session unless other arrangements are made. Please notify me if any problem arises during the course of your therapy regarding your ability to make timely payment. My fee is $200 per 45 minute session. I reserve the right to periodically adjust this fee. I will give you prior notice of fee increases.

In addition to my fee for sessions, I charge for other professional services such as report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals, preparation of records or time spent providing any other service requested by patients.

CANCELLED/MISSED APPOINTMENTS
A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than twenty-four (24) hours' notice, you will be billed according to the scheduled fee or according to the rules of the patient's health plan.

DELINQUENT ACCOUNTS
If your account becomes delinquent (past 30 days) our office may begin collection procedures. We will attempt to contact you directly. However, if your account remains delinquent we may utilize the services of an outside collection agency, we may retain an attorney, or small claims court action may be taken.

LITIGATION CHARGES
If I am required to attend a deposition, hearing or other legal proceeding in the capacity of your current or past therapist, you will be billed at $400 per hour for my time, including preparation and travel time as well as the time I spend at the legal proceeding. If you are a current or past client, my testimony will not include any forensic opinions.

I strongly advise that you not involve me in any litigation as it is outside of my role as your therapist and is not in the best interests of your therapy.

EMAIL or TEXTING
Other than, scheduling appointments, I will not accept, review or respond to emails or texts from you or someone on your behalf. Please limit email or text communication to scheduling only.

INDEPENDENT PRACTICE
As you know, I share office space with other independent business and practicing mental health professionals who share certain administrative functions. While the members share office space in the suite, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no member of the office space can have access to them without your specific, written permission.

TERMINATION OF THERAPY SERVICES
I may terminate therapy services at my discretion. I may consider termination if:

- **I do not believe that I can provide you with effective treatment**
- **Your needs are outside the scope of my experience or training**
- **You desire to terminate treatment or we mutually agree it is time to terminate treatment**
- **You fail to comply with my treatment recommendations**
- **A conflict of interest develops**
- **You fail to pay my fee on a timely basis**
- **You or I believe it is in your best interest**

If either you or I decide to terminate therapy services, I will recommend at least one closure session.

ADDRESS CHANGES
Please advise me if you change your address, telephone number, place of employment or insurance coverage or companies.

ACKNOWLEDGEMENT AND AGREEMENT FOR INFORMED CONSENT

I have read and fully understand this Consent for Treatment form.

Patient/Parent/Guardian Name Patient/Parent Guardian Signature Date

Patient/Parent/Guardian Name Patient/Parent Guardian Signature Date