PDJ PSYCHOTHERAPY & CONSULTING, INC.
Patricia D. Johnson, Psy.D.
Licensed Marriage & Family Therapist
16055 Ventura Boulevard, Suite 721
Encino, CA 91436
(818) 990-9008
www.drpatriciajohnson.com

TELEMENTALHEALTH & OFFICE POLICIES/INFORMED CONSENT

Appointments: I usually meet with my patients once a week, but other schedules may be necessary as we plan your treatment together. The usual and customary fee for an individual session is One-Hundred-fifty Dollars ($150.00) per session and sessions are usually 50 minutes long. Conjoint/Couples and Family sessions are Two-Hundred-ninety-five dollars ($295.00) per 60-minute session. Sessions longer than 60-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Representative will be notified of any fee adjustment in advance.

Cancellations/No Shows: Patient must cancel/reschedule an appointment by telephone, twenty-four (24) hours in advance or be charged the regular fee. Patient will also be held responsible for the fee if patient does not appear for an appointment.

Payment for Services: Services must be paid for at the time they are rendered, unless other arrangements have been made.

Telemental Health Services: Patient agrees to Telementalhealth services via Face Time, telephone, or other agreed upon Platforms. Patient understands that these third party applications potentially introduce privacy risks. All available encryption and privacy modes when using these applications have been enabled. Dr. Patricia D. Johnson and PDJ Psychotherapy & Consulting, Inc. cannot control confidentiality on patient's end of communication. If during a session, we get disconnected, I will try re-connecting with you and I urge you to do the same.

Insurance Reimbursement: Patient will be provided, upon request, with a receipt/statement that describes the psychotherapy services patient has received. This receipt may be submitted to patient's health insurance provider if necessary. There is no assurance that patient will receive any reimbursement. Please check the terms of your coverage as many insurance plans do not cover mental health services unless the providers are part of that health care plan. Patient is responsible for full fee.

Confidentiality: In general, information disclosed in psychotherapy sessions is privileged, and must be held confidential unless patient gives written permission authorizing release of information. However, the law defines certain, exceptional circumstances in which the therapist is required to disclose information: when there is reasonable suspicion of child abuse, elder abuse or dependent adult abuse, or where the client threatens violence to an identifiable victim. Disclosure may also be required in certain legal proceedings.

Emergencies: My practice does not typically deal with psychiatric emergencies; therefore it may be twenty-four (24) hours or more before I am able to return phone calls.

Fictitious Business Name (DBA): I have been advised and understand that Dr. Patricia D. Johnson is also doing business as (DBA) PDJ Psychotherapy & Consulting, Inc.

The Therapeutic Process: Possible benefits that may be gained from participating in therapy include a better ability to handle or cope with marital, family, and other interpersonal relationships; greater understanding of personal goals and values; and /or resolving specific concerns brought to therapy. In working to achieve these potential benefits, however, therapy may involve the experiencing of significant discomfort. Seeking to resolve issues between family members, marital partners, and other persons can similarly lead to discomfort, as well as relationship changes that may not be originally intended.

I have read and I understand the above stated office polices and agree to abide by the conditions state herein.

_____ _____

(Signature) Date

_____

(Signature)

PLEASE READ AND (SIGN IF NECESSARY):

TREATMENT OF A MINOR

The parent(s) or legal guardian of a minor (anyone under 18 years of age) must consent to treatment.

I, _____, (parent/legal guardian) give consent for the treatment of _____ (minor(s) in counseling/psychotherapy with Patricia D. Johnson, Psy.D., Licensed Marriage and Family Therapist (License #MFC32475). I understand that the office policies described above apply during the course of treatment for my child.

_____ _____

(Please Print Name) Date

_____

(Signature)