Mara L. Bronstein, Psy.D. (PSY 24355)
Office Address: 881 Fremont Avenue, Suite B8, Los Altos, CA 94024
Mailing Address: P.O. Box 3763, Los Altos, CA 94024
Phone: (650) 231-4835 Email: info@drmara.com
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Informed Consent

Thank you for seeking my services.
This document contains information about my professional services and business policies.
Please read it carefully and we will discuss it at our first meeting.

Therapy Services: I provide individual and group psychotherapy. The therapy process is a partnership between you and the therapist to work on areas of concern or dissatisfaction in your life, develop growth and insight, help you achieve your desired goals, and improve your overall well-being. In order for therapy to be effective, it is necessary for both of us to take an active role in this process. Participation involves being honest with me, completing outside assignments when appropriate, and providing on-going feedback about the process.

While therapy is often beneficial for many people, some people may not find it helpful. The therapy process may evoke strong feelings and sometimes it produces unanticipated changes in one's behaviors, thoughts, and feelings. In order for you to maximize your experience, it is helpful to discuss any questions or discomfort you may be experiencing during the therapeutic process with me. My goal is to make this work a collaborative process.

I reserve the right to deny services to individuals whose concerns are beyond my scope of competence as well as to any individual that abuses or misuses services in any manner, e.g. non-compliance with treatment, frequent missed appointments, delinquent payment, etc. If I am unable to offer you services for your specific needs, I will discuss other local treatment options and possible referrals with you.

Fees: Payment is due at each session. You may pay by credit card, personal check, or cash. Receipts are available upon request. As a Medicare provider, I will submit claims on your behalf. You are responsible for any co-insurance, co-payments, or deductible amount as determined by your insurance. I am obligated to collect these fees. For other insurance plans, I am considered an out-of-network provider. At your request, I will give you an invoice that you may use to seek reimbursement according to your plan and benefits. You will be responsible for paying the full fee at the time of the session.

Termination: You have the right to decide not to enter therapy with me and to seek services elsewhere. If you feel that you are not making progress towards your goals, you may terminate the therapeutic relationship at any time. Upon request, I will provide you with referrals for therapists or agencies in the community. In effort to help you transition, I request one last in-person session, so we can discuss your next steps and review your experiences in therapy. You will be responsible for any outstanding payments for services missed or received.

Missed/Cancelled Appointments: You will be charged a full session fee for any missed appointment or an appointment that was cancelled within 24 hours of your scheduled appointment. Please call **(650) 231-4835** to cancel your scheduled appointment. Please note that insurance companies do not pay for missed or late-cancelled sessions and you will be responsible for the full fee.

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Emergencies: In the event of an emergency please contact 911 or visit your local emergency room. The Santa Clara County Suicide Hotline is (855) 278-4204 and the Mental Health Call Center is (800) 704-0900.

Confidentiality: Under most circumstances, all information about you, in written or verbal form, obtained in the therapy process (including your identity as a client) will be kept confidential. Information will not be disclosed to any outside person(s) or agency without your written permission except in certain situations, which include, but are not limited to:

a. If you are determined to be in imminent danger of harming yourself, someone else, or someone else's property;
b. If a family member notifies me that you have threatened to harm another person;
c. If you disclose abuse or neglect of children, the elderly, or vulnerable adults;
d. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain access to your records;
e. Or where otherwise legally required.

Due to possible limitations in confidentiality, please limit your use of email to the purpose of scheduling appointments. The above is considered a summary. If you have questions about specific situations or any aspects of confidentiality, please feel free to discuss your concerns with me.

Access to Records: Upon request, you may review your therapy records. You may request to review the complete records or a summary of the records prepared by me. Please submit your request in writing. You may be charged a reasonable fee for administrative costs related to generating copies of your records. Therapy records are maintained for 7 years after your last contact with me.

The signature here shows that I have read, discussed, and understand this information. I agree to comply with the points presented above.

_____ _____
Signature of client (or person acting for client) Date

_____
Printed name