Allison B. Harrington, Psy.D.

Licensed Clinical Psychologist

1891 East Roseville Parkway Suite 100 Roseville, CA 95661 (916) 789-7082x311

allison@aharringtonpsyd.com

OFFICE POLICIES AND PROCEDURES

Confidentiality

I will treat all of the information you share with great care. It is your legal right that sessions and records are kept private and confidential. There are few situations in which confidentiality is not protected.

Child or Elder Abuse: In my professional capacity, whenever I observe or have reasonable suspicion that a child has been the victim of abuse or neglect, I legally must make a report to the appropriate local authorities/agencies. The same holds true if I observe or have knowledge of an incident in which an elder adult has suffered physical abuse, abandonment, isolation, neglect or financial abuse.

Judicial or Administrative Proceedings: There are several situations in which I may be required to break confidentiality when you are involved with a court proceeding: a) When you, your lawyer or personal representative provides written authorization b) When I am presented with a court order c) When you are being psychologically evaluated by a third party or an evaluation is court ordered d) When you initiate a Workers' Compensation suit claiming emotional damage, and I am requested to make a report.

Safety Situations: If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to contact the intended victim(s) and the police. If I suspect that you are in such a condition as to be dangerous to yourself (such as suicidal) I may release relevant information to prevent danger and maintain health and safety.

Taping: I may videotape sessions for training and consultation purposes. Your initials in the space provided indicate that you are willing to be videotaped and understand the following:

1) I may request the taping be stopped at anytime or portions erased.
2) The use of the tapes is only for training and consultation and will be erased after they have served their purpose.
3) The tapes are confidential and only shared within the context of the consultation/supervision group.

Client Signature_____

(Additional) Client Signature_____

Couples Therapy: I have a "no-secrets" policy when conducting marital/couples therapy. This means that if you participate in couples therapy, I am permitted to use information obtained in an individual session or from individual communication (phone calls, email, etc…) with the other parties in treatment. I will not disclose confidential information about your treatment to any other source unless all

persons who participated in the treatment with you provide their written authorization to release such information.

Minors and Confidentiality: Communications between myself and patients who are minors (under the age of 18) are confidential. However, parents/guardians who provide authorization for their child's treatment are often involved. Consequently, in exercising my professional judgment I may discuss the treatment progress of a minor patient with the parent/guardian.

Appointments

Typically, I conduct 50-minute therapy sessions once or twice a week. The frequency may increase or decrease based on need. It is my experience that therapy usually works best when a regular ongoing appointment is scheduled and kept consistently. I consider our sessions very important and ask you to do the same. The time we schedule is set-aside exclusively for you. Try not to miss a session if you can help it. When you must cancel, please provide 24-hours notice, otherwise, I charge for missed appointments not canceled 24-hours in advance. When three sessions are missed without providing 24-hours notice, I may terminate sessions with you and provide referrals for counseling elsewhere.

Therapist Contact

I do not have a receptionist; therefore, I operate with an "electronic office." This means you may contact me by phone or email: texting is not a contact option.

Phone: You may leave a message for me at any time on my confidential voicemail. Please be sure to leave your name, number, best times to reach you and a brief message regarding the nature of the call. Non-urgent phone calls are returned within 24-hours Monday through Friday. In the event of an emergency please call 911 or the 24-hour Sacramento mental health crisis line at 1-888-881-4881.

Internet and Mobile Phone Use: In the event that we correspond via the Internet or mobile phones, it is important that you are aware of the limits of confidentiality related to these devices. Although all possible effort will be made to make sure your privacy and confidentiality is maintained, these communication methods are not 100% protected from outside interference. You have the right to request that information not be shared in this way.

Payment For Services

Per 50-minute session, my fee is $150.00. Payment is required at the time services are rendered in the form of cash, credit card, or personal check. I can provide a document (superbill) that may be used as a receipt and to submit to your insurance company for reimbursement if you have out-of-network mental health coverage. If your insurance denies reimbursement for any service, you are still responsible for payment. Sessions conducted over the phone are charged at the same rate as in-

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person sessions. Phone calls that exceed 20 minutes will be charged a standard session fee. Returned checks will be charged a $27.00 fee in addition to the original charge. I examine my fee schedule yearly and may change fees. You will be notified in writing of any changes and are encouraged to let me know if there are any concerns.

Statement of Principles and Complaint Procedures

I fully abide by all the rules of the American Psychological Association (APA) and by those of the California Board of Psychology (state licensing board). Problems can arise in our relationship, just as in any relationship. If you are not satisfied with any area of our work, please raise your concerns with me immediately. Our work together will be more effective if your concerns are worked out promptly. I will make every effort to hear your complaints and seek solutions to them.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. I will discuss a plan for your termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If one of us determines that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include: referral, changing your treatment plan, or terminating therapy with me.

Our Agreement

I, the client(s) (or his/her parent or guardian), understand I have the right not to sign this form. I understand I can choose to discuss my concerns with Dr. Harrington, before I start formal therapy. If at any point during the treatment I have questions about any of the subjects discussed here, I can talk with Dr. Harrington about them, and she will do her best to answer them.

I have read, or have had read to me, the issues in this informational form. I have discussed those points I did not understand, and have my questions, if any, fully answered. I agree to act according to the points covering in this informed consent form. I hereby agree to enter therapy with Dr. Allison Harrington (or to have the client enter therapy), and to cooperate fully and the to the best of my ability, as shown by my signature.

Signature:_____ Date:_____
Printed Name:_____
(Additional client signature)
Signature:_____ Date:_____
Printed Name:_____
Therapist Signature:_____ Date:_____