YANA PELEG, PH.D.
LICENSED PSYCHOLOGIST # PSY 21199
CONSENT TO TREAT

Client's Name ________________________________

Welcome to my office. It is my sincere intent to provide you with high quality professional psychological services.

Your first appointments will essentially focus on the problem or concern that motivated you to seek a consultation. This will include a history of the problem and an assessment of the best treatment modality suited to your need.

Sessions are typically scheduled one to three times per week for 45-50 minutes "clinical hour." This time is reserved only for you and it is important that you are punctual for our meetings. When a cancellation of scheduled sessions is unavoidable there will be no charge if 24 hours notice is given. Otherwise there will be a full fee charged for missed appointment.

I want you to know that the law, professional ethics and good clinical judgment require that whatever is discussed within your therapy sessions is not disclosed to anyone without your written permission. However, there are exceptions to confidentiality you should be aware of: 1) when you waive your privilege of confidentiality, 2) in cases of suspected child abuse, dependent adult, or elder abuse, 3) when you report a harmful act to self or others and 4) following a court order. I am obligated by law in these instances to release information, to file a child abuse report, provide safety in cases of danger to self, or notify authorities and victims of potential harm.

My hourly fee is $200. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, report writing, travel time, and the time spent performing any other service you may request of me.

Fees are due and payable at the time of services. Insurance coverage varies from 100% coverage to no coverage at all and it is your responsibility to verify your insurance coverage before starting treatment. You will receive a receipt from me, which you will send to your insurance company for reimbursement. By signing this form you agree to give me a permission to talk to your insurance company for the purpose of service verification and reimbursement should such need arise.

Please ask questions, be honest, and most of all participate as best as you can in the process of therapy. I will do my best to serve your as well. Please keep this sheet for future reference and sign the duplicate copy attached.

I am often not immediately available by telephone. While I am usually in my office between 9 AM and 5 PM, I probably will not answer the phone when I am with a patient. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are calling after my office hours, on a weekend, or during my time off, or are otherwise unable to reach me and feel that you can't wait for me to return your call, contact your family physician, please call 911 or go to the nearest emergency room and ask for the psychologist or psychiatrist on call.

Again welcome. I look forward to working with you.

I have read and understood the preceding information.

Name ____

Signature ____ Date __________