

PILAR STEIN, LCSW

310.990.5148

LCS 21233

Welcome to my office. As a licensed therapist, I am governed by laws, regulations, and the code of ethics of my profession. This document outlines these policies and my professional services. It is important that you resolve any questions you have about these policies or about your participation in therapy.

Your Rights: Your participation in therapy is voluntary and you may end treatment at anytime. You always have the right to refuse suggestions, ask questions, and seek alternate services. Any formal complaints about my practice should be directed to the California Board of Behavioral Sciences. You have a right to a summary of your treatment records barring situations wherein a summary may be contraindicated.

Risks and Benefits: Psychotherapy has been shown to have benefits such as improved relationships, problem-solving, and reduced feelings of distress. However, the nature of the material often discussed in therapy can also lead to the experiencing of uncomfortable feelings like sadness, guilt, anger, frustration, fear, helplessness, etc. Addressing relationship issues can sometimes lead to unintended results. Because therapy is different with every individual, no guarantees can be made as to the outcomes you will experience.

Confidentiality: In general, the privacy of communication between a therapist and a client is legally protected and information can only be disclosed with your written permission. Similarly, in couples or family therapy, each legally competent participant must give consent for disclosure. Following are the legally and ethically defined exceptions:

- a) threats of bodily self-harm or threat of grave disability or threats of serious physical harm to another
- b) when there is reasonable suspicion child abuse, elder abuse, or dependent adult abuse
- c) situations when a judge/court orders treatment or clinical records and/or testimony

In the case of danger to others, the law requires I notify police and warn intended victim(s). In the case of danger to self, I am ethically bound to inform the nearest support person or otherwise act to prevent self-harm. If abuse of a child, elder or dependent adult is suspected, I am required to notify state authorities. Finally, I must comply with any court orders to supply documents and/or testimony, but I am ethically bound to protect this information as much as possible.

To provide you with optimal services, I will sometimes consult other professionals without revealing identifying information. A consultant is also legally bound to hold the information confidential. If you don't object, I will only advise you of these consultations when it seems important to our work.

Session length: Sessions typically last fifty minutes. If you arrive late to session, the session will still end on time to avoid running over into the next person's session. Please call me if you are running late.

Cancellations: Appointment times are reserved specifically for you. If you cannot keep a scheduled appointment, please call me with as much advance notice as possible. Full session fees are charged for cancellations made less than 24 hours prior and for sessions missed without canceling.

Fees: I accept checks (payable to "Pilar Stein, LCSW") or cash; payments are due at the time of the session unless other arrangements have been made. A \$15 fee is charged for returned checks, and this may require future payments be made in cash. Please notify me as soon as possible if circumstances arise affecting your ability to pay. My fees will generally be increased annually, but adequate notice will be given and financial hardship taken into consideration.

Insurance: Invoices can be provided for insurance or tax purposes upon request. If insurance is used, you will continue to pay therapy fees to me and seek direct reimbursement from your insurer. Should your insurer require me to complete ongoing documentation, I may need to charge a prorated fee for this service.

Emergency Procedure and Contact Information: I am often not immediately available by phone, but messages can be left for me at any time. I will make every effort to return your call the same day excepting Sundays and holidays. Please specify in your message if your call is urgent. If you have an emergency, you should not wait to try and reach me—you should call 911 for help. I am willing to check in between sessions when it is necessary for your welfare; however, calls longer than 15 minutes are prorated at the session fee. When indicated, phone sessions can be scheduled in place of face-to-face sessions, incurring the normal session fee. Please be aware that when calling me between sessions and when leaving voice messages, cellular phone service is in use; the nature of this technology does not guarantee a confidential conversation.

Email Contact: My email address is for the purpose of making initial contact only. Be advised that email is never totally confidential and that no therapeutic services will occur via email.

Vacations/Absences: I will give advance notice of my absences and as needed, I will ensure availability of another competent therapist for your consultation.

Tobacco, Alcohol, and Other Drugs: Please do not use tobacco in my office or waiting room. It is also important to refrain from using alcohol or other drugs before sessions. Arriving to session under the influence of alcohol or drugs will result in termination of the session and charge of a full session fee.

Minor Clients: If you are under 18, the law may allow parents/legal guardians access to your treatment records. It is my policy to request an agreement from parents that entitles you to a confidential relationship with me. If they agree, I will then only provide them with summaries about our progress unless you are at risk of harming yourself or another, or you are in harm's way. Barring emergencies, any information I disclose to parents will first be discussed with you.

Your signature below indicates that you have read and understood the information in this document and agree to abide by its terms and policies during our professional relationship.

Client Name Printed _____ Signature _____ Date _____

Client Name Printed _____ Signature _____ Date _____

Parent/Guardian Name Printed _____ Signature _____ Date _____

Parent/Guardian Name Printed _____ Signature _____ Date _____

Therapist Name Pilar Stein, LCSW Signature _____ Date _____