ERIN JOYCE, PSY.D.

Clinical Psychologist (Lic. # PSY25785)

(424) 535-4126 | drjoyce@drerinjoyce.com

CLIENT AGREEMENT FORM

Prior to your initial session, please read this form carefully. When we meet, we will review key information as well as address any questions you may have. ***Please initial each blank space if you understand and agree with what is stated.***

Confidentiality: In accordance with California law, the information you disclose in therapy is confidential and not to be released or made accessible to anyone else without your written permission. By law, the following exceptions apply and may require relevant information be given to others: (1) danger to self; (2) danger to others; (3) grave disability; (4) abuse or neglect of a child (under age 18), disabled person (over age 18), or elderly person (over age 65); (5) when a court of law issues a legitimate subpoena; and (6) when a collection service needs to be used for unpaid bills.

_______ I acknowledge that I have received a copy of the *Health Insurance Portability & Accountability Act (HIPAA) Notice of Privacy Practices*, which informs me of my rights regarding protected health information (PHI).

_______ I acknowledge that I have received a copy of the *Psychotherapy Services and Policies* form. I agree to engage in treatment with Dr. Joyce and to abide by the policies to the best of my ability.

_______ I understand that my therapist may discuss my case in a confidential manner for the purposes of clinical consultation.

In Case of Emergencies: Please call Dr. Joyce at (424) 535-4126. If you are unable to reach Dr. Joyce directly, please call 911 or go to your nearest emergency department.

Payment of Services:

_______ I agree to pay in full for services rendered by Dr. Joyce.

_______ I understand that my fee is ████ per 50 minute session and ████ per couple or family therapy session. I also understand that extended sessions or non-emergency phone therapy will incur an additional prorated fee.

_______ I understand that cancellations of therapy appointments must be made at least 24 hours in advance and that I will be charged **100%** of the full session fee for missed appointments or cancellations less than 24 hours in advance.

_______ I understand that any unresolved bills for services or missed appointments may results in disclosure of my name, telephone number, SSN, and address to a collection agency or small claims court.

_______ I understand that payment may be made via cash, credit card, or a check made out to: Erin Joyce Walsh, Psy.D.

Treatment Outcome: There are no guarantees that treatment will be successful, although most clients do make significant progress. The length and outcome of treatment is based on your motivation for treatment, how long you have had the presenting problem(s) and symptoms, the skill of the therapist, your incorporation of what you learn in therapy into your life outside of therapy, and other factors.

I (WE) HAVE READ AND UNDERSTAND THE INFORMATION ON THIS PAGE AND HAVE RECEIVED A COPY OF THE HIPAA NOTICE. I (CLIENT) WILL REQUEST A COPY OF THIS *CLIENT AGREEMENT FORM* IF SO DESIRED.

_________________________________ _________________

Signature of Client (or parent of minor) Date

_________________________________ _________________

Signature of Therapist Date