ROB GRELLMAN, PSY.D.

3880 S. Bascom Avenue, Suite 101; San Jose, California 95124 • Voice Mail 408-486-6711 • Google 408-320-8568

CONSENT FOR TREATMENT & INFORMATION

Name(s): _____ DOB(s): _____ Age(s): _____

Address: _____ City: _____ Zip: _____

Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

Spouse's Work Phone: (____)_____ Cell Phone: (____)_____

SS#: _____ - _____ - _____ Spouse's SS#: _____ - _____ - _____ Other's (Son / Daughter) SS#: _____ - _____ - _____

Employer: _____ Spouse's Employer: _____

Name of Emergency Contact: _____ Phone Number: _____

Physician's Name & Phone: _____

Please List any Medications You Take: _____

Email Address(s) : _____

Children (ages): _____

INTRODUCTION

The following information has been written to familiarize you, the client, with the basic terms and conditions that promote a successful therapeutic experience.

I am a licensed psychotherapist. I hold a Doctorate Degree in Clinical Psychology, a Masters Degree in Counseling & Psychology, and a Bachelor's Degree in Theology & Psychology. My counseling experience entails psychotherapy for children, adolescents, families, couples, and individual adults through different facets such as residential treatment, elementary and high schools, agencies, and private practice.

ABOUT THERAPY

Participating in therapy can help you learn new and important things about yourself and others as well as new and better ways of handling feelings or problems. While there are no guarantees, coming to therapy should help you feel better and produce beneficial results.

You know therapy is working when you feel less worried, afraid or anxious; problems are being resolved; relationships are improving or you come to feel better about yourself. *Sometimes you may feel worse before you feel better - this is a part of the therapeutic process and usually means you are making progress.*

You can at any time ask me questions about the process of therapy, including procedures and methods.

You also have the right to know generally about my experience and training as well as the terms, conditions and content of the therapy. You have the right to end therapy at any time.

Paying for Psychotherapy

My fee is currently $150.00 per clinical hour (approximately 45-50 minutes). I *only* accept Credit Card for payment.

Name As It Reads On CC: _____ CC#: _____

Expiration Date: _____ CVV Code: _____ Zip Code Bill Sent To: _____

Please note that I do NOT bill insurance companies, but upon *your* request, I will give you a statement of receipt to turn into your insurance company for reimbursement; I send monthly statements.

If you have a PPO Plan – Insurance ID # : _____ Group # : _____

((OVER))

CONFIDENTIALITY - PLEASE INITIAL: _____

All information disclosed within the client's therapy sessions, including case notes and records, will be treated as confidential and, under some circumstances, as privileged. No information will be revealed to anyone not present in therapy without the permission of the client or a legally authorized representative unless an applicable legal or ethical exception exists.

- However, **I AM REQUIRED BY LAW** to report any suspected child abuse (*including the past*), elder or dependent adult abuse, and any situation where the client threatens violence to an identifiable victim(s).
- The **LAW ALSO PERMITS ME** to break confidentiality when the client presents a danger of violence to others and or other's property or is likely to harm him or herself unless protective measures are taken.
- In addition, disclosures may be required in certain legal proceedings and actions such as a subpoena by the court. Please note that I do not write letters nor will I speak to lawyers; *I respond only by subpoena*.

All questions regarding confidentiality, the release of information and waiver of privilege, etc., need to be brought up with myself.

TREATMENT OF MINORS AS INDIVIDUAL CLIENTS

When a client who is a minor is in individual therapy, the parent or guardian has the right to ask for information about the minor's therapy, and the therapist, acting in the best interest of the minor client, has the right to limit the amount of information disclosed.

If the minor client is a participant in any legal proceedings raising the protection of all client/therapist communications as "privilege," then no disclosure will be made of any of the content of the therapy except by written waiver of privilege, given in writing by the parent, guardian or other lawful representative acting on behalf of the minor client.

In situations where parents are divorced, I require a copy of the Custody Order & I will establish contact with the other parent.

CANCELLATION POLICY - PLEASE INITIAL: _____

Cancellation needs to be made at least 50 hours (2 days for *weekly schedule*) or 100 hours (4 days for every-other-week schedule) in advance from the time of your appointment to avoid being charged for the session. **PLEASE DO NOTE THAT YOU WILL BE RESPONSIBLE FOR FULL PAYMENT OF SESSION IF YOU DO NOT CANCEL BEFORE YOUR SCHEDULED APPOINTMENT. ALSO NOTE THAT CANCELLATION NEEDS TO BE BY PHONE – NOT E-MAIL.**

TELEPHONE CALLS - PLEASE INITIAL: _____

Your calls are important to me. I check in for my messages several times a day during the weekdays. I will return your calls as promptly as possible. **PLEASE DO NOTE THAT PHONE CALLS LONGER THAN 10 MINUTES WILL BE CHARGED AT A PRO-RATED HOURLY FEE.**

EMERGENCIES

In times of crisis, I will give you the earliest available appointment or arrange for emergency care. If I am not available, please call one of the following emergency numbers: Emergency Psychiatric Services at 408-885-6100, Suicide and Crisis Services at 408-279-3312, or Contact Hotline including Parental Stress at 408-279-8228.

I have read and understood all the information on this form. I agree to the above conditions, and to avail myself and/or the named minor to the professional services of Dr. Rob Grellman, licensed marriage and family therapist, and consent accordingly to the use of individual, couples, family, and or group psychotherapy, and/or psychological testing.

Signature of Client: _____ Signature of Parent(s) or Guardian: _____

Signature of Spouse: _____

Signature of Therapist: _____ Date: _____