Peter Gleiberman,Psy.D.
Registered Psychological Assistant, PSB94022367
424-262-9445

CLIENT INFORMATION FORM

Client Name:	Today's Date:
Address:	Birth Date:
	Age:
Home Phone:	
Work Phone:	
Cell Phone:	
OK to leave a message? Home? Yes / No Cell? Yes / No Work? Yes / No	
Email: _____ OK to email? Yes / No	
Occupation / Employer / School:	
Emergency Contact: Name, Phone, Relationship to you:_	
Relationship Status (circle one): Single Married/Partnership Separated Divorced Widowed	
Names and ages of persons living in your home and their relationship to you:	
Have you ever had previous counseling? If yes, when and for how long?:_	
Have you ever been hospitalized for substance abuse, alcoholism, an eating disorder or any other psychiatric illness?_____Have you ever been hospitalized for other medical reasons?_____If yes, please describe:	
Are you currently taking any prescribed medication?_____If yes, list medication(s):	
Referral Source:	
Do you plan on submitting reimbursement forms to your insurance? Yes / No (If yes, please provide insurance card to be photocopied)	

Lysa Eastman, Ph.D.
Licensed Psychologist PSY26892

1200 S Pacific Coast Hwy, Ste. F • Redondo Beach, CA 90277
310.218.7442 • dreastman@healthymynds.com

www.healthymynds.com

INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Client Signature **Date**

HIPPA NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notices.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. For treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control- I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants,

consultants, and others to make sure that I am in compliance with applicable laws.

3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.

2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.

3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.

4. If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.

5. To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.

6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.

7. If disclosure is mandated by the California child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.

8. If disclosure is mandated by the California Elder/ Dependent Adult Abuse Reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.

9. If disclosure is compelled or permitted by the fact that you tell me of a serious/ imminent threat of physical violence by you against a reasonably identifiable victim or victims.

10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. For specific government functions. Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.
14. For Workers' Compensation purposes. I may provide PHI in order to comply with Worker Compensation laws.
15. Appointment reminders and health related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.
16. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records)m or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that may be of interest to you.
18. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: when compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
19. If disclosure is otherwise specifically required by law.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.
1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment of your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed and authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any further uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI
These are your rights with respect to your PHI:

A. The Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
B. The Right to Inspect and Copy. You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.
C. The Right to Receive Confidential Communications by Alternative Means and at Alternative Locations. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). Upon your request, I will send your bills to another address.
D. The Right to an Accounting. You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your request, I will discuss with you the details of the accounting process.
E. Right to a Paper Copy. You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

V. COMPLAINTS
If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact: **Lysa Lee Eastman, Ph.D., 1200 South Pacific Coast Highway, Suite F, Redondo Beach CA 90277, (310) 218-7442**.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. EFFECTIVE DATE OF THIS NOTICE
This notice went into effect on April 14, 2003.

I acknowledge receipt of this notice:

Client Name: _____

Signature: _____

Date: _____

Peter Gleiberman,Psy.D.
Registered Psychological Assistant, PSB94022367
424-262-9445

Limits of Confidentiality in Psychotherapy

I, _____, do understand and agree that my disclosures and communications are considered privileged and confidential, except to the extent that I authorize a release of information, or under certain other conditions below. I also understand that confidential and privileged information may be released without my permission in the following circumstances recognized by guidelines established by the American Psychological Association:

1. Where abuse of children or harmful neglect of children, the elderly, or disabled or incompetent individuals is known or reasonably suspected.
2. Where the validity of a legal last will and testament of a former client is contested in court and a lawful subpoena is served.
3. Where such information is necessary for the psychotherapist to defend against a malpractice action or a claim is brought by the client.
4. Where an immediate threat of physical violence against a readily identifiable victim is disclosed to the psychotherapist.
5. In the context of civil commitment proceedings where an immediate threat of self-inflicted damage is disclosed to the psychotherapist.
6. Where the client, by alleging mental or emotional damages in litigation, puts his or her mental state at issue.
7. Where the client is examined pursuant to a court order.

In addition to acknowledging an understanding of the limits of confidentiality in psychotherapy, my signature below acknowledges receipt of the California Notice Form: Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Mental Health Information.

My signature also acknowledges receipt of a copy of Peter Gleiberman Psy. D., Registered Psychological Assistant – Client Services Agreement.

_____ _____
Signature of Client Date

Peter Gleiberman,Psy.D.
Registered Psychological Assistant, PSB94022367
424-262-9445

Psychotherapist – Client Services Agreement

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPPA), a federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. HIPPA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPPA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims make under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you are experiencing. There are many different methods I may use to help you overcome the problems you wish to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during sessions and throughout the week.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what your work will include and a treatment plan to follow, if you decide to continue therapy. You should evaluate this information along with your own opinion of whether you feel comfortable working with me. I believe that one of the most important aspects of the process of change is rooted

in the working relationship between the psychotherapist and the client. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

I am registered by the California State Board of Psychology as a Psychological Assistant and I am supervised by Dr. Lysa Eastman (PSY 26892). A Psychological Assistant is the title given by the state of California to a trained professional that has met numerous criteria and is registered to practice psychotherapy under the supervision of a licensed psychologist. If you have any questions or concerns you would like to discuss with my supervisor, Dr. Lysa Eastman, please feel free to contact her at (310) 218-7442.

MEETINGS

I typically conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services that you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session per week at a time that we agree on, although some sessions maybe be longer or more frequent. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled sessions.** If it is possible, I will try to find another time during the week to reschedule an appointment.

PROFESSIONAL FEES

My hourly fee is $160.00 for a single individual and $200.00 for couples or family therapy. 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 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other services you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. (Because of the difficulty of legal involvement, I charge $300.00 per hour for preparation and attendance at any legal proceeding.)

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 9 AM and 7 PM, I will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voicemail (that I monitor frequently). 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. In emergencies, we can decide upon additional ways that you will be able to reach me. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by state law and/or HIPPA. But, there are some situations where I am permitted or required to disclose information without either your consent or Authorization:

• I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

• If you intend to use Health Insurance I may use a billing company. As required by HIPPA, I have a formal business associate contract with this company, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.

• Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

• If a client threatens to harm herself/himself, I may be obligated to seek hospitalization for her/him, or to contact family members or others who can provide protection.

• If you are involved in a court proceeding and a request is made for information about the professional services I have provided you and/or the records thereof, such information is protected by psychologist-patient privilege law. I cannot provide any information without your (or your legally-appointed representative's) written authorization, a court order, or compulsory process (a subpoena) or discovery request from another party to the court proceeding where that party has given you proper notice (when required) has stated valid legal grounds for obtaining PHI, and I do not have grounds for objecting under state law (or you have instructed me not to object). If you are involved in, or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

• If a government agency is requesting the information for health oversight activities pursuant to their legal authority, I may be required to provide it for them.

• If a client files a complaint or lawsuit against me, I may disclose relevant information regarding the client to defend myself.

• If a client files a worker's compensation claim, I must, upon appropriate request, disclose information relevant to the claimant's condition, to the workers compensation insurer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

• If I have knowledge of a child under 18 or I reasonably suspect that a child under 18 that I have observed has been the victim of child abuse or neglect, the law requires that I file a report with the appropriate governmental agency, usually the county welfare department. I also may make a report if I know or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well being is endangered in any other way (other than physical or sexual abuse, or neglect). Once such a report is filed, I may be required to provide additional information.

• If I observe or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if an elder or dependent adult credibly reports that he or she has experienced behavior including an act of omission constituting physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, the law requires that I report to the appropriate government agency. Once such a report is filed, I may be required to provide additional information.

• If a client communicates a serious threat of physical violence against an identifiable victim, I must take protective actions, including notifying the potential victim and contacting the police. I may also seek hospitalization of the client, or contact others who can assist in protecting the victim.

• If I have reasonable cause to believe that the client is in such mental or emotional condition as to be dangerous to him or her self, I may be obligated to take protective action, including seeking hospitalization or contacting family members or others who can help provide protection.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or

concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that disclosure would physically endanger you and/or others or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. If I refuse your request for access to your records, you have a right of review, (except for information supplied to me confidentially by others) which I will discuss with you upon your request.

MINORS AND PARENTS

Clients under 18 years of age who are not emancipated can consent to psychological services subject to the involvement of their parents or guardian unless the psychologist determines that their involvement would be inappropriate. A client over age 12 may consent to psychological services if he or she is mature enough to participate intelligently in such services, and the minor client either would present a danger of serious physical or mental harm to her or himself or others, or is the alleged victim of incest or child abuse. In addition, clients over age 12 may consent to alcohol and drug treatment in some circumstances. However, clients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records unless I determine that access would have a detrimental effect on my professional relationship with the client, or to his/her physical safety or psychological well-being. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and parental involvement is also essential, it is usually my policy to request an agreement with minors (over age 12) and their parents about access to information. This agreement provides that during treatment, I will provide parents only with general information about the progress of treatment, and the client's attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. (In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.)

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. This may include the use of a collection agency.

INSURANCE

Some insurance companies require copies of treatment plans or summaries, or copies of your entire Clinical Record when considering payment. Before I can disclose this information, both you and I must receive written notification from the insurer stating what they are requesting, why they are requesting it, how long it will be kept and what will be done with the information when they are finished with it. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

TERMINATION OF THERAPY

I believe that how long you remain in therapy or in counseling is a matter best left in your hands. If you want counsel in this matter, I will certainly provide it for you. Yet it is you who makes the ultimate decision about continuing or ending. Our work together will be a resource of your use; it is your right to feel free to end the use of that resource whenever your own wisdom suggests that termination is in your best interest. Since the therapy relationship occupies a position of importance to me as well as to you, I hope that the decision to end therapy will be discussed candidly and thoroughly with me in advance of that decision. Leave takings often proceed in the most growth enhancing fashion when they can be fully discussed and a sense of closure achieved.

CONSUMER PROTECTION

If you are uncertain about whether the work you are doing with me is of real benefit to you, I encourage you to talk about your concerns with me. I also would like to acknowledge your right to seek outside consultation from some other professional, and I have absolutely no objection to your getting other opinions about your problems and/or about what you are experiencing in your relationship with me.

If at any time you feel that you are being harmed by your experience with me, I would hope that you would discuss the matter frankly in your sessions. If you are dissatisfied with the response you receive, you have the right to report your concerns to the California Board of Psychology, the agency charged with regulating the practice of psychology in this state. Information about this agency is posted in my offices.

CONCLUSION

I look forward to the work we are about to undertake together. I hope that you will find your experiences with me helpful and meaningful to you. I understand that a decision to seek professional counsel for problems in living is always a difficult and important one – one that is never made lightly. I will strive to be my best as I aid in the search for solutions to your concerns.

Peter Gleiberman, Psy.D.
PSB94022367

Client Signature **Date**

Peter Gleiberman,Psy.D.
Registered Psychological Assistant, PSB94022367
424-262-9445

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (Name), hereby authorize Peter Gleiberman, Psy.D., to exchange clinical information with the individual or agency listed below:

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Telephone:_____ Fax:_____

This agreement shall be valid from _____ to _____

I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation or modification to my provider's office address. However, my revocation or modification will not be effective until my provider receives it.

The provider will observe applicable rules of confidentiality regarding any information, written or verbal, that is received under this agreement. It is understood that this exchange and/or receipt of information is intended solely for the purpose of furthering treatment.

A photocopy of this authorization shall be considered as effective and valid as the original and I understand that I have a right to receive a copy of this document.

_____	_____	_____
Client Name (print)	Client Signature	Date