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OFFICE POLICY AND INFORMED CONSENT TO TREATMENT

Welcome to my private practice. As a patient of Dr. Mariela Costello, you have made an important commitment to improving or enhancing the quality of your relationships, and you will be supported in achieving your goals. This form is designed to help you make informed decisions about the services you receive. Please read and sign this document, which contains information concerning m professional services and business policies.

Psychological Services: Psychotherapy varies depending on the personality of both the patient and the therapist and the particular problem(s) that the patient brings to treatment. It is a specialized treatment designed to offer effective long-lasting assistance. Areas of concern frequently addressed include depression, anxiety, significant loss, and relationship issues. Psychotherapy can also be sought for personal growth and self-improvement. It is a collaborative effort on the part of both the therapist and the patient and will require an active effort on our part. My normal practice is to conduct an evaluation lasting one to two sessions. During this time we can both decide whether I am the best person to provide the services you need to meet your treatment objectives. I will usually schedule a weekly session at a mutually agreed upon time. The psychotherapy sessions last approximately 50 minutes.

Confidentiality: All information disclosed in our sessions is confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. These circumstances are: When there is a reasonable suspicion of child or elder abuse; when there is reasonable suspicion that the patient is likely to hurt himself/herself unless protective measures are taken; or when the patient presents a threat of violence to others. Your privacy is of the utmost importance. Every effort is made to protect the confidentiality of your treatment.

Payment for services: My current fee for service is $200 for a 50 minutes session, and is due at the time of each session. (Unless a sliding scale fee has been established). A cost of living increase may occur on an annual basis. My fee will be pro-rated and charged for extended sessions, report writing, and phone calls longer than 15 minutes. A statement will be mailed and/or handed to you at the end of each month. You may use this statement if you are seeking reimbursement from your health insurance. If I am an

"In-Network" provider with your insurance, I will bill the insurance for their standard fees for service. If you have insurance, I will bill the insurance for each session and I will collect a co-payment at the time of the session if one is due. You may need to obtain pre-authorization for treatment if you are planning on using your health insurance.

Cancellation Policy: Your session is reserved each week for you. For this reason I charge my full hourly rate for appointments cancelled with less than 48 hours notice, unless we can reschedule your meeting within the same week. A 24 hours notice is acceptable in cases of sickness, or in case of an emergency.

Emergency Procedures: Dr. Costello is available to speak by telephone after hours in circumstances involving clinical emergencies. If you have an urgent concern, please indicate as such when you leave your message. If your situation is an acute emergency that requires immediate attention, please call 911 or go to your local hospital emergency room.

Risks and Benefits of Treatment: The state of California requires by law that I inform you of any possible risks in seeking treatment. While I can assure you that there are no dangers associated with psychotherapy, some patients report feeling a little worse before they feel better. "Risks" sometimes include experiencing feelings such as sadness, anxiety, anger, helplessness, and/or frustration. However, the benefits of therapy can be life changing and long lasting. This may include better coping skills, an increased ability to recognize and manage emotions, and improvement in personal relationships.

I look forward to our work together. If you have any questions or concerns about the information contained in this form, please don't hesitate to discuss them with me.

Your signature below indicates your consent for treatment and agreement to pay my fees.

Print Name _____

Signature_____

Parent/Legal Guardian (if client is under 18) _____

Date _____