

MICHELLE HOBBY, Ph.D.

Clinical Psychologist

License PSY 21171

Psychotherapy & Consultation
Children, Adolescents, and Adults

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CONSENT FOR TREATMENT & PATIENT AGREEMENT

Welcome to my practice. Your therapy is an important joint venture in which you and I (and/or your child/family) will work together to understand the problems that you are having and to explore your options and obstacles in resolving those problems. This document contains information about my professional services and business policies. Should you have any questions about these at any time, I will be happy to answer them.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on many factors, including the personalities of the patient and psychologist, your early experiences, your life stage, and your goals. There are several different approaches that can be used. Psychotherapy requires an active effort on your part and a working relationship with me in which together we identify the issues you would like to resolve.

Psychotherapy can have both benefits and risks. Since therapy often involves discussing difficult aspects of your life, you may experience uncomfortable feelings and changes in your behaviors/thoughts. This is a normal part of the therapy process. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful. It often leads to a significant reduction of feelings of distress, better relationships, and resolutions of specific problems.

Our first few sessions will involve an evaluation of your needs (or your child's needs). I will assess if I can be of benefit to you (or your child/teen). I do not accept patients who, in my opinion, I cannot help. In such a case, I will provide you a number of referrals that you can contact. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include, a diagnosis, and a treatment plan if we agree that treatment will continue. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them when they arise.

As you make progress, we should reevaluate your treatment. Usually, we will come to a mutual understanding that you have reached your treatment goals and consolidated your gains. You do, however, have the right to stop treatment at any time and I will provide you with referrals to other qualified professionals whose services you might prefer. Also, if at any point during psychotherapy I assess that I am not effective in helping/treating you, I am obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, I would give you a number of referrals that may be of help to you.

The process of termination is generally one of the most important times in therapy. The length of the termination depends on many factors, including the length of your treatment. It usually consists of at least four visits, but may take several months. In the case of children, I ask that I work with parents to set a termination date before it is discussed with the child.

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MY EDUCATION AND TRAINING

I am a licensed Clinical Psychologist in the state of California. I received my doctorate in Clinical Psychology from California School of Professional Psychology-Alameda. I also have a Master's degree in Clinical Psychology from San Francisco State University. I began my clinical work/training in 1996 and I am a member of the American, California, and San Diego Psychological Associations. For further information about my practice please visit my website at <http://www.DrMichelleHobby.com> or <http://www.scrippsranhpsychologist.com> . If you have questions about the specifics of my training, experience, and/or license please ask for clarification at any time.

CONFIDENTIALITY

With certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me, without your prior written permission. The following are legal exceptions to your right to confidentiality. Should one of these situations occur, I will make every effort to discuss it with you fully before taking any action.

- If I reasonably suspect that a person under 18 or over 65, or a disabled person, is being abused or has been abused, I must file a report with the appropriate state agency.
- If a patient threatens to harm him/herself, I may be obligated to seek hospitalization for the patient, or to contact family members or others who can help provide protection.
- If a patient 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 patient, or contact others who can assist in protecting the victim.
- I may find it helpful consult with professional colleagues about my work from time to time. In these consultations, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the 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.
- If you are involved in a court proceeding and a request is made for information about the services that I have provided you and/or the records of them, such information is protected by psychologist-patient privilege law. I cannot provide any information without your written authorization, a court order, or compulsory process (a subpoena) or discovery request from another party to the court proceeding where 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 patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I must, upon appropriate request, disclose information relevant to the claimant's condition, to the worker's compensation insurer.

MINORS AND PARENTS

Unemancipated patients 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 patient, or to his/her physical safety or psychological well-being. Because privacy in psychotherapy is often crucial to successful progress, particularly with adolescents, and parental involvement is also essential, it is usually my policy to request an agreement with minors and their parents about access to information.

PROFESSIONAL RECORDS

Except in unusual circumstances in which disclosure would physically endanger you and/or others or makes reference to another person (unless such other person is a health care provider), you may examine and/or receive a copy of your clinical record, if you request it in writing. You will also be charged a fee for any preparation time which is required to comply with an information request.

APPOINTMENTS

Psychotherapy appointments are usually scheduled once a week for 50 minutes per visit, although sometimes visits can be more frequent. An appointment is a commitment to our work. We agree to meet here and to be on time. If I am ever unable to start on time, I ask for your understanding, and I assure you that you will receive the full time agreed to. If you are late, we will probably be unable to meet for the full time. I will provide one month's notice of my planned absences, usually about 4-6 weeks per year. For short absences and therapist illness, I will attempt to reschedule your appointment as soon as possible.

CANCELLATION POLICY

Because the scheduling of an appointment involves the reservation of time set aside specifically for you, a minimum of 24 hours notice is required for rescheduling or canceling an appointment. The full session fee will be charged for sessions missed without such notification. The phone number for leaving a cancellation message is (858) 414-2523.

PROFESSIONAL FEES

My fee per 50-minute psychotherapy or consultation visit is \$____. Bills are to be paid at the time of each visit by the patient in the form of cash or check (unless you are covered by an insurance plan that I am a preferred/in-network provider for). Your co-pay due each visit is \$____.

Having your check made out prior to the session allows for full use of your session time. Telephone conversations (lasting longer than 10 minutes), treatment summary preparation, release of information, reading records, etc. will be charged at the same rate, unless indicated and agreed otherwise. When fees are not paid for services rendered, a collection agency may be used and given appropriate billing and financial information. If a payment by check results in insufficient funds a \$50 fee will be assessed. Please notify Dr. Hobby if any problem arises during the course of therapy regarding your ability to make timely payments.

If you become involved in legal proceedings that require my participation, you will be charged for all of my professional time, including preparation and travel time, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$400 per hour for preparation for, travel to and from, and attendance at any legal proceeding. In cases of separated or divorced parents, one parent must assume full financial responsibility for all services.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS

If you have health insurance, it will usually provide some coverage for mental health treatment. In most cases I do not bill insurance companies directly although I can provide you with a bill/receipt for you to submit to your insurance. However, you, and not your health insurance carrier, are responsible for full payment of my fees (with the exception of clients with approved mental health sessions by accepted insurance companies and in some single case agreements).

If you choose to seek reimbursement from your health insurance carrier or I seek reimbursement from one of the insurance panels listed above, disclosure of confidential information may be required by your carrier in order to process the claims. Please refer to the Federal Health Insurance Portability and Accountability Act (HIPAA) form with regard to the use and disclosure of your Protected Health Information (PHI). Only the minimum necessary information will be communicated to the carrier. By signing this contract, you are consenting to a release of information about your case to your health plan for claims, certification and case management for the purposes of treatment and payment. Dr. Hobby has no control or knowledge over what insurance companies do with the information she submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance.

I have reviewed, understand, & received a copy of Dr. Hobby's HIPAA-Notice of Privacy Practices: _____Please Initial

CONTACTING ME & CRISIS NUMBERS:

I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voicemail, which I check a few times per day, unless I am out of town. If an emergency situation arises, please indicate it clearly in your message. I will make every effort to return your call on the same day you make it, with the exception of calls on weekends and holidays. Also, I do not return telephone calls between 8:00 p.m. and 8:00 a.m. on weekdays, during weekends, and planned vacations. If you are unable to reach me and you are in crisis, you can contact the following; your local physician/hospital, crisis line 1-800-479-3339, National Suicide Prevention Lifeline (800) 273-TALK (8255), National Hopeline Network (800) 784-2433, or the emergency dispatcher at 911. If I am unavailable for an extended time, I will provide you with the name of a colleague whom you can contact if necessary.

INFORMED CONSENT FOR TELEPHONE, ELECTRONIC, AND MAIL CONTACT:

Ordinary privacy precautions such as pin codes, voice mail boxes, and locked fax, mail, and secured computers are by no means foolproof, so that your confidentiality is always compromised when communicating by electronic devices or mail. Nor is deletion or shredding of private material a totally safe means of disposal, so that you are always at risk of breaches in confidentiality when electronic or mail communication of any type is used for private information. Your use of such means of communication with Dr. Hobby constitutes implied consent for reciprocal use of electronic and mail communication as well. By signing this contract, you agree to and understand the following:

1. Many people feel comfortable communicating via email, because they have installed programs designed to detect spyware, viruses, or other dangerous software. However, there is no guarantee that such programs will work 100%.
2. Sent and received emails are stored on both Dr. Hobby's and your computer until deleted. Dr. Hobby may or may not delete such emails. Any saved emails will be kept in a password-protected account that only Dr. Hobby has access to.
3. In addition, whenever you send an email, it is stored in cyberspace. It is possible for authorities and system administrators to locate and read such emails under various circumstances. This is not a policy of Dr. Hobby, but is due to the nature in which email is transmitted using the internet and other services/networks. For more information on this, please contact your Internet Service Provider or email service.
4. By signing below, I understand/agree the disclosures listed above regarding communicating with Dr. Hobby via e-mail, phone, fax, and mail. I also agree that if I send an email to her and request a response via email, that I am willing to accept the above-stated risks. I understand that Dr. Hobby cannot guarantee an e-mail response due to time constraints in her practice. I also agree that I will not use email for emergencies. Instead I will utilize e-mail correspondence with Dr. Hobby for scheduling and non-clinical matters.

Sign below if you give permission for Dr. Hobby to initiate/send/place the following to you: emails/mail/telephone calls-messages:

Print Name: _____ Signature _____ Date: _____

Print your email clearly: _____

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Please sign below to acknowledge your informed consent to this agreement.

I have read the above information, received a copy of this form, and have had an opportunity to ask questions which clarify the conditions under which I consent to treatment. I give permission to **Michelle Hobby, Ph.D.** **Clinical Psychologist** to provide psychotherapy, evaluation, consultation, and/or testing for myself or my child/family.

Name of patient

Signature of patient

Date

Name of parent or guardian

Signature of parent or guardian

Date

Name of parent or guardian

Signature of parent or guardian

Date