Andy Sussman, L.C.S.W.
Psychotherapy

4155 24th Street, San Francisco CA 94114
5313 College Avenue, Oakland CA 94618

CONSENT TO TREATMENT

California law requires this consent.

I understand that therapy is a mutual effort. Progress depends on many factors including motivation, effort and other life circumstances such as interactions with family, friends and others. The length of treatment varies depending upon the nature and severity of the problems as well as the aforementioned factors. I understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

I understand and hereby consent to the following:

1. I acknowledge that I am hereby being informed that, under California law,:
    a. If a patient communicates to a therapist a serious threat to harm an identifiable person, the therapist must warn that person and the police
    b. If the therapist suspects child abuse or neglect, or abuse of a helpless adult or of an elder, a report must be made to the designated agency;
    c. If a patient seems dangerous to self or others or unable to care for him/herself, then hospitalization may be required.

2. I understand that:
    a. Information and records--otherwise confidential--and/or testimony concerning me and or my family must be provided in the event of a Court order;
    b. In litigation or official proceedings, including but not limited to the collection of fees, information and records—otherwise confidential—and/or testimony concerning me and/or my family may have to be provided in limited circumstances without my specific consent, in accordance with applicable law.

3. I understand that this consent covers me and any of my minor children involved in treatment.

4. My consent is voluntary and, except for Items 1 and 2 (limits on confidentiality) and urgent consultations, I may withdraw my consent to future disclosure at any time by writing a letter to Mr. Sussman.

5. I have the right to end treatment at any time. Mr. Sussman has the right to end treatment at his discretion for reasonable cause, including but not limited to the following:
    a. failure to follow the treatment plan;
    b. failure to pay;
    c. treatment is no longer helpful or warranted.

6. This consent is in effect from this date until treatment is terminated.

Signed: _____ Date: _____

Printed Name: _____

CONSUMER INFORMATION STATEMENT

1. Andy Sussman is a Licensed Clinical Social Worker in the state of California. My work involves helping people with a wide range of problems. I see adolescents, adults, individuals, couples and families.

2. FEES: A check, agreed upon electronic payment service or cash payment will be made to Andy Sussman at the time of each psychotherapy appointment. Your fee will be $200. You may be charged for telephone calls, writing reports or letters. Periodically, I will raise my fees. Please notify me if any problem arises during the treatment regarding your ability to make timely payments. Failure to pay as agreed is a breach of your fiduciary duty and, under California Law, I may use other means to collect payment.

3. CANCELLATION POLICY: Once we have agreed upon a regular time or multiple times to meet during the week, I will reserve those times for you and you will be responsible to pay for that time. **With 7 days advance notice, you are allotted (5) cancellations per year without being charged.** If I receive less than 7 days advance notice, and we are able to reschedule the appointment that same business week (Monday-Friday) for a mutually convenient time, you will not be charged for the missed session. If we are not able to reschedule with less than 7 days notice, or if you do not show up for our appointment, you will be charged for the session. You will, of course, not be charged if I cancel our appointment. Rescheduling is more probable with several weeks' notice.
If we have agreed to a reduced frequency schedule, you will be charged for any missed or cancelled appointments.

4. TELEPHONE: You may call my voicemail at anytime. When you call, please leave your name, phone number, and a brief message. If I do not call you back within a reasonable period of time, please call and leave another message.

5. EMERGENCY: If you experience a medical or psychiatric emergency please call 911 or go directly to the nearest emergency room.

6. CONFIDENTIALITY: Privacy is a basic right of any individual who seeks psychotherapy. Therefore, all consultations and records are confidential. No one will be advised of your participation in therapy unless you specifically request in writing that this be done. I participate in regular professional consultations. In such cases, neither your name nor any identifying information about you is revealed.

I have read, understand, and agree to the policies set forth in this statement.

Signed: _____ Date: _____

Printed Name: _____

OUTSTANDING BALANCE AND CREDIT CARD AUTHORIZATION

Once we have established a regular payment history you may pay for your sessions at the end of that month. If you have an outstanding balance for 28 days from the last session, your credit card will be charged to cover the balance due and credit card processing fees.

By completing this form I, _____ (Printed Name) am authorizing my credit card be charged to pay for balance due for psychotherapy services, cancellations, missed appointments and processing fees per Cancellation Policy, p.2, #3.

I have read, understand and agree to the payment and credit card authorization policy for services provided by Andy Sussman:

_____

Signature Date

Credit Card Information

Card Holder Name:

_____

Card Holder Signature:

_____

Card Type: □Visa □Mastercard □Discover □AmEx

Billing Address: _____

City: _____ Zip: _____

Account Number: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

Expiration Date: __ __/__ __

CVV (3 digit code): __ __ __

ANDY SUSSMAN, LCSW
PSYCHOTHERAPY

SAN FRANCISCO &
OAKLAND OFFICES

415.944.7466

CLIENT INFORMATION FORM

Name _____ Date of Birth ____/____/____

Age _____ Relationship Status _____ Soc. Sec. Number _____

Home address (city, state, zip code):

_____

_____

Please list your phone numbers and check next to the number(s) where you prefer to be contacted:

▫ Home (_____)_____ Message may be left at this number ▫ Yes ▫ No

▫ Work (_____)_____ Message may be left at this number ▫ Yes ▫ No

▫ Cell (_____)_____ Message may be left at this number ▫ Yes ▫ No

Email Address _____

Have you previously been seen for therapy and/or mental health treatment? ▫ Yes ▫ No

If yes, please list the provider(s), treatment(s), duration(s):

_____

_____

_____

How were you referred to my practice?

_____

_____ _____
SIGNATURE DATE