



### *Consent to Treatment*

*You have decided to embark on a powerful journey known as psychotherapy, a decision of strength and courage. Know that we consider the psychotherapeutic relationship to be one of sacred trust. This letter serves to inform you about the therapeutic process, give you some information and answer questions about the professional relationship between therapist and clients. Psychotherapy cannot insure the successful resolution of the issues you bring to it. Human beings are far too complex and life is too uncertain. However, it is our experience as therapists that most people can gain some value from the therapeutic process. Know that as we journey together new, often unforeseen destinations may appear. The therapeutic process may not only affect you, but also relationships, work and other areas of life. There are alternatives and many adjuncts to psychotherapy. These include, but are not limited to, medications, support groups and complimentary modalities. We will be happy to discuss any alternatives you want to consider at any time.*

*We have a number of client expectations about the professional relationship we embark on with each client. We expect you to keep your appointments. Please remember that someone else may want this time. Please give our other clients, their obligations, relations and your therapist the courtesy of a 48-hour notice if you must cancel an appointment; otherwise, you will be charged for this time. Insurance will not pay for broken appointments; thus, you may incur a charge for this time. Our current fee is \$250 per session unless we have made prior financial arrangements. We accept cash, personal checks, and credit cards. We work with a number of insurance companies via managed care contracts and we are not responsible for filing claims. You are required to pay your current fee at the time services are rendered. Other insurance plans (out of network) are accepted but you may be required to pay the difference and/or any other co-payments.*

*We also charge for our time when you require written correspondences, court-related issues, and military VCMS issues. This is billed according to the amount of time utilized with a minimum fee of \$250/hour. This would include correspondence such as letters to other practitioners, disability applications, etc. Insurance will not pay for correspondence. We do not charge for customary insurance filing. Telephone consults are also billed at regular rates. The first 5 minutes we consider a professional courtesy to our relationship; thereafter, the time is billed at regular rates to the nearest quarter hour unless otherwise agreed. Sessions are 50 to 55 minutes in length. Our therapists take a few minutes of an hour between clients to relax, let go of the last session and prepare for the next one. You may reach us via voicemail/emails at your leisure.*

*Although the client-therapist sessions will be intimate psychologically, it is important for you to understand that the client-therapist relationship is professional and not social. All contact will be limited to sessions you arrange with your therapist. Sessions are usually held in one of our offices. Your sessions should focus on your concerns exclusively. You will learn a great deal about your therapist the longer you work together; our therapist may occasionally share experiences and struggles with some regularity a model for clients. Nonetheless, you will still be experiencing the therapist in a professional role solely. If you should encounter your therapist outside of the office, the therapist will speak with you only if you initiate the contact; this allows you to maintain the privacy of your psychotherapeutic relationship. Although this may seem artificial and/or awkward, it is the best way to promote a good psychotherapeutic relationship.*

*Length of treatment will be determined by therapist and client together and will vary based on the client's needs and severity of symptoms. If for any reason, we feel that it is necessary or advisable to end treatment before you would like to, we will provide you with appropriate alternative referrals.*

*When a minor is the client, parents may be requested to participate in treatment through family sessions or parenting sessions. A parent/guardian is required to remain on-site during all individual sessions of a minor client. Parents may request information regarding their child's treatment, but we request that parent's respect a certain level of confidentiality as to the content of their child's session. Privacy allows children and adolescents to better benefit from*



1061 El Monte Avenue, Suite B \* Mountain View, California 94040 \* Office: 650-386-6753 Fax: 650-282-3468

*the therapy process as they can more openly express themselves. We will inform parents of any significant safety concerns that the minor may disclose.*

*Our therapists attend peer consultation with colleagues biweekly. They may discuss the work occurring in your session in these sessions while maintaining your anonymity. Our therapists use an eclectic approach to therapy, meaning that they utilize a variety of therapeutic models. Our therapists work diligently to use what is most helpful for each individual rather than take any one approach exclusively to achieve skills development. We hope this information is helpful to you. If at any time during your relationship your therapist, you have any questions please feel free to ask.*

We are aware that Joelle Rabow Maletis LLC may use, without consent, confidential information under the following limited circumstances: 1) We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law. 2) For reporting victims of abuse, neglect or violence to government authorities, including social service or protective service agencies. If we have reasonable cause to believe that a child, dependent adult and/or elderly adult has been abused, we must report that belief to the appropriate authority. If we have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, we must report that belief to the appropriate authority. 3) For judicial or administrative proceedings such as in response to a court order, search warrant or subpoena. You will be informed in advance if this is the case. 4) If we determine, or pursuant to the standards of psychological profession should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.

*We are aware that we (or our child/children) may stop treatment with this therapist at any time. We understand that we may lose other services or may have to deal with other problems if we stop treatment. (For example, if our treatment has been court-ordered, we will have to answer to the court.) As our therapists are in session most of the day, they do often check voice mail and return messages at the end of the day. If your call is non-urgent, we will respond as soon as possible within 24 hours. If you are in a life and death emergency situation, dial 9-1-1 for assistance or go immediately to your local emergency department.*

*We are aware that an agent of my insurance company or other third-party may be given information about the type(s), cost(s), and providers of any services we receive. We understand that if payment for the services we receive here is not made, the therapist may stop treatment. Our signature below shows that we understand and agree with all of these statements. We have been given the opportunity to ask questions regarding this information.*

*You hereby seek and consent to take part in the treatment provided by this agency. We understand that developing a treatment plan with this therapist and regularly reviewing our work toward the treatment goals are in our best interest. We agree to play an active role in this process. We understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.*

---

Signature of Client/Legal Guardian or Legally Authorized Representative      Date

Joelle Rabow Maletis, MA, Ed, MA, LMFT  
Psychotherapist (MFC51094)  
Clinical Director/Supervisor

Massiel Torres, MS  
Clinical Social Work Associate (ASW79865)  
Denishia Robbins, MS  
Clinical Social Work Associate (ASW76034)