MARNEL TUCKER, PSY.D
CLINICAL PSYCHOLOGIST

INFORMED CONSENT FOR TREATMENT

Please read this Consent for Treatment carefully and in its entirety. It contains information about my policies, procedures, and practices, and it clarifies the terms of my professional therapeutic relationship with you or your child. Be sure to ask me any questions that you may have regarding its content before signing it.

I, _____, authorize and request that my psychotherapist, Marnel Tucker, Psy.D, provide psychological examinations, assessment, interventions and/or diagnostic procedures that now or during the course of my care as a patient are advisable. The frequency and type of intervention will be decided between my) therapist and me. I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement. I understand that there is an expectation that I will benefit from these interventions but there is no guarantee that this will occur. I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about therapy, as the process can sometimes be uncomfortable.

PSYCHOLOGICAL SERVICE is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

CONFIDENTIALITY
All interactions with Marnel Tucker, Psy.D, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. No record of counseling is contained in any academic, educational or occupational file. You may request in writing that your therapist release specific information about your counseling to persons you designate.

All information disclosed within sessions, including that of minors, is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law. Disclosure may be required in the following circumstances:

- When there is a reasonable suspicion of abuse to a child, dependent or elder adult.
- When the client or credible third person communicates a serious threat of bodily injury to others.
- When the therapist has a reasonable belief that the client may be a danger to him or herself, others, or the property of others.
- When disclosure is otherwise required by law.
- If you introduce your emotional conditional into a legal proceeding, or your therapist is subpoenaed to give testimony.

I participate in regular professional consultation. In such cases, neither our name (or your child's) of any identifying information about you (or your child) is revealed.

EMERGENCY TREATMENT
If you have a life-threatening emergency, please call 911. I am not able to provide 24-hour availability. I usually return calls within 24 hours or the next business day, excluding holidays. When I am out of town or otherwise unavailable, a qualified professional will cover for me by checking my telephone voicemail.

FEES/PAYMENT
Payment is due at the start of each session unless other arrangements have been made. Please notify me if any problem arises during the course of your therapy regarding your ability to make timely payments. My current fee is $150.00 per 50- minute session. I reserve the right to periodically adjust this fee. Longer sessions are pro-rated and discussed in advance. I accept cash, check, debit, and credit cards. I do not take insurance. However, I can provide a statement of services for you to submit to your insurance for reimbursement. I am considered an out-of- network provider.

UNPAID SESSIONS
If payment arrangement is provided and your payment is not received within 60 days, we have the right to pursue payment through a collection agency. This will involve disclosing your name and any relevant information related to your unpaid balance

LATE ARRIVAL POLICY
Our appointments will begin promptly at the agreed upon time. If you are going to be late, please call and let me know, and I will wait for the agreed upon time. Otherwise, I will wait 15 minutes beyond the start time of the session. If you have not arrived, I may leave and you will be charged for the full payment of the session.

CANCELLED/MISSED APPOINTMENTS
A scheduled appointment means that the time is reserved only for you. I require 24-hours' notice if you need to cancel your appointment. If an appointment is missed or cancelled with less than twenty four (24) hours' notice, you will be charged according to the scheduled fee.

CREDIT CARD AUTHORIZATION FORM
I require all clients to fill out a credit card authorization form prior to beginning therapy. This information is kept confidential and in a securely locked file cabinet. By signing this form you authorize your therapist, Marnel Tucker, Psy.D., to charge your credit card in the event of a missed/cancelled appointment or if my twenty four (24) hour cancellation policy is not honored. Please advise me if there are any changes to the information on your form. I will update this form periodically.

LITIGATION CHARGES
If I am required to attend a deposition, hearing or other legal proceeding in the capacity of your current or past therapist, you will be billed at $150 per hour for my time, including preparation and travel time as well as the time I spend at the legal proceeding. If you are a current or past client, my testimony will not include any forensic opinions.

TELEPHONE CONTACT
You may call my voicemail (562) 833-3238 when necessary. I am most often not immediately available by telephone. I typically return calls within 24 hours or the next business day, excluding holidays. Telephone sessions are available at the regular 50-minute rate. Calls that result in therapy will be charged at a pro-rated amount.

TERMINATION OF THERAPY SERVICES
I may terminate psychotherapy services at my discretion. I may consider termination if:

- I do not believe that I can provide you with effective treatment
- Your needs are outside the scope of my experience or training
- You desire to terminate treatment, or we mutually agree it is time to terminate treatment
- You fail to comply with my treatment recommendations
- A conflict of interest develops
- You or I believe it is in your best interest
- Any threat to provider's safety will result in immediate termination

If either you or I decide to terminate psychotherapy services, I will recommend at least one closure session.

ADDRESS CHANGES
Please advise me if you change your address, telephone number, or place of employment.

ACKNOWLEDGMENT AND AGREEMENT FOR INFORMED CONSENT
I have read and fully understand this Consent for Treatment form. I agree to abide by the terms and conditions of this Agreement, and I consent to participate (or for my child to participate) in psychotherapy with Marnel Tucker, Psy.D.

_____
Client/Parent/Guardian Name (please print)

_____
Signature of Client/Parent/Guardian

_____
Date