Informed Consent - Relationship Agreement

This agreement is intended to provide _____
with important information about the practices, policies, and procedures of:

Teje Aliberti, a Licensed Professional Clinical Counselor/Marriage + Family Therapist - California & Hawaii residents.
(California License NO. LPCC891 & MFC50709 & Hawaii License No.MFT-580)

THE FOLLOWING HAS BEEN DISCUSSED AND YOU, AS THE CLIENT OF TEJE ALIBERTI UNDERSTAND THE FOLLOWING CLIENT-THERAPIST RELATIONSHIP AGREEMENT:

CONFIDENTIALITY – I am bound to hold our conversations private. The only conditions under which information may be shared are:
At your request and with your written permission or in the event of;

1. A child (under 18) or elder (over 65) is being abused
2. A danger to self **or**
3. A danger to others.

TELEMEDICINE AGREEMENT – You, the client, hereby consent to engaging in telemedicine with Teje Aliberti, MFT, as part of my consultation, treatment, transfer of medical data, and education using interactive audio, phone, video, or data communications.

You, the client, understand telemedicine may also involve the communication of my medical/mental information, both orally and visually, to health care practitioners located in California/Hawaii or outside of those states. You, the client, understand you have the following rights with respect to telemedicine:

(1) the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during my therapeutic conversation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

(4) I understand telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g., face-to-face services) I will be referred to a psychotherapist who can provide such services in my area.

(5) I understand there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improved, and in some cases may even get worse. I may benefit from telemedicine, but results cannot be guaranteed or assured.

(6) I understand that I have a right to access my medical information and copies of medical records in accordance with California and Hawaii law.

CLIENT LITIGATION – I will not voluntarily participate in any litigation or custody disputes. I generally do not write or sign letters nor provide records or testimonies unless I am legally mandated by the courts. If I am legally mandated to provide materials or appear for proceedings, by signing this agreement, you agree to reimburse the time spent on preparation, travel or other time spent making myself available for any litigation related work. You will be billed at my usual and customary hourly rate of $200.

FEE AGREEMENT – We have agreed to a fee of $ per 50-minute session. Your fee is due at the end of every session. If you are covered by insurance, you have signed the release for me to bill your insurance and you are responsible for a Copay of $ at the end of every session.

EMAIL/TEXT/TELEPHONE CALLS – I will attempt to respond to communications within 24 hours. I do NOT provide emergency services. If you have an emergency, please call 911, or go to the nearest emergency room. There is no charge for communications of 15 minutes or less. If our communications extend beyond the 15 minutes, I will notify you, we will end our conversation and/or schedule a billable session.

CANCELLATION POLICY – It is customary to ask for 24 hours advance notice for cancelled therapy appointments. If cancellations are provided within a shorter time frame, you will be asked to pay for the session. Cancellations or change of appointment times should be left on my confidential voicemail at 310-995-9772. Text messages are also acceptable.

ACKNOWLEGEMENT – Your signature below indicates you have read & understood the information contained above. Our signatures below confirm we are both in agreement with the terms of the client-therapist relationship. Please ask questions that may not have been addressed or need clarification.

Client Signature	**Date**
Teje Aliberti, MA, LPCC, LMFT	**Date**