West Hollywood Counseling
Joey Sarcoz, MA, LMFT #53995
8235 Santa Monica Blvd., Suite 400
West Hollywood, CA 90046
Phone: 424-335-0144

Consent for Services

By signing this form, I acknowledge that Joey Sarcoz, MA, LMFT and I have discussed the risks, benefits, purposes, and alternatives of psychotherapy. I certify that I **consent** to receive mental health treatment from Mr. Sarcoz. Sessions are scheduled to be **50** minutes in length; if I arrive late, we must still finish on time. I understand that I may voluntarily discontinue treatment at any time, but outstanding fee balances will remain due and collectable. Also, Mr. Sarcoz reserves the right to terminate treatment at any time, for any reason, if in his clinical judgment my treatment is not progressing. If this occurs, Mr. Sarcoz will make reasonable efforts to refer me to another provider or treatment facility, and agrees to consult with future providers if I request this in writing.

I acknowledge that we have discussed the **limits of confidentiality** according to the laws of the State of California, including such conditions as being in danger of serious harm to myself or serious harm to others, when issues of child, elder, or dependent adult abuse are involved, when required in the event of legal proceedings (such as subpoenas), or in certain client safety emergency situations. I realize that any communications via **cell phones** or **emails** may lack full confidentiality due to technical limitations. I acknowledge that I have been given written information on the privacy practices of Mr. Sarcoz's office and my rights regarding protected health care information according to federal **HIPAA** regulations.

I acknowledge that **emergency services are not available**, and Mr. Sarcoz is not available by pager. Messages left on the main number for Mr. Sarcoz's practice will be returned as promptly as possible, but for any emergencies, I must call 9-1-1 or visit the nearest hospital Emergency Room.

I acknowledge that the cancellation policy for appointments requires **48 hours notice**, or the full session fee (not merely my insurance co-payment) will be charged, unless Mr. Sarcoz can accommodate me with another appointment time, schedule permitting, *within the same business week*. It is expected that once a client begins treatment, a client will commit to attending most weekly sessions and not cancel except for illness, work travel, or similar high-level commitment. A client who does not attend at least 75% of weekly sessions is subject to their standing appointment time being reassigned to another client who can commit to weekly attendance.

I acknowledge that full **payment for services is due at the time services are rendered**, by either check or cash. Payments for missed sessions must be paid by delivery or mail *within the same business week they occur*. I acknowledge that while I may have insurance benefits, billing to insurance is not permitted for unlicensed clinicians and that I hire Mr. Sarcoz for services on a private-hire basis only. I agree that if two sessions have outstanding balances, scheduling of a third session will be suspended until payments are in order, or Mr. Sarcoz will offer referrals to at least three free or low-cost treatment resources. I acknowledge that my questions regarding this Consent have been answered thoroughly.

Client Signature Date

cc: Client