

CONSENT FOR SERVICES

The undersigned client or responsible adult* consents to and authorizes mental health services from

Tamar Counseling Services ~ Deborah Vinall, PsyD LMFT

Welcome to Tamar Counseling Services, the private psychotherapy practice of Deborah Vinall, Licensed Marriage and Family Therapist, license # 45229. I have been practicing psychotherapy in the State of California since 2004 and became licensed through California's Board of Behavioral Sciences for independent practice as an LMFT in 2007. I hold a Bachelor of Science degree in Human Development, a Master of Arts degree in Marriage and Family Therapy, and a Doctorate in Clinical Psychology.

My approach to treatment may vary depending upon presenting problem, developmental stage, and goals of the client. I view problems through the lens of attachment with attention to neurobiology. Many traumas and mood disorders are effectively treated through EMDR (Eye Movement Desensitization and Reprocessing) or Brainspotting, two related, specific modalities in which I am certified. I incorporate somatic and Internal Family Systems work along with teaching practical tools for self-regulation and grounding. We can discuss treatment approaches to determine the best fit for your needs and goals.

In signing below, you attest that you understand:

1. You have the right to be informed of and participate in the selection of evaluation, treatment methods, and case management services to be provided. You have the right to select a therapist of your choosing.
2. These services are voluntary; you have the right to terminate treatment at any time. If I assess that I am not the best fit to meet your needs, I will refer you to another provider. In either scenario, the decision to terminate should be discussed in session so that treatment can be concluded in a supportive manner.
3. As with any health care service, there is minor risk in undergoing treatment. You may experience a temporary increase in psychological / emotional discomfort as issues are brought to the surface and addressed. You are encouraged to discuss this with your therapist and voice your needs regarding pacing and establishing psychological / emotional safety throughout treatment.
4. Professional therapy never involves sexual contact.
5. Progress in treatment is dependent upon multiple factors, to include how long the problem has been present, the number of issues you are addressing, your attendance at sessions, and your work between sessions on applying changes processed to your personal life. The first few sessions focus primarily on assessment, understanding your past and current life situation, goal setting, and treatment planning.
6. When treating a couple or family, TCS will not take the role of "secret-keeper" between family members that are a part of the treatment.
7. All of your information, to include the very fact of being in treatment, is kept confidential. There are some exemptions mandated and allowed by law, to include if your therapist judges you to be an imminent danger to yourself or someone else, if your therapist becomes aware of child, elder, or dependent adult abuse, or as necessary to collect unpaid bills.
8. You are responsible for payment at the time of services rendered. TCS does not bill insurance, but will provide an itemized invoice upon request should you choose to pursue reimbursement from your insurance provider. Acceptable forms of payment include cash, check, credit or debit card, electronic funds transfer, California Victim Compensation Program funds, or health care flexible savings account funds. There will be a \$50 charge for all checks returned as NSF. The cost of a "therapy hour" is \$225.
9. A "therapy hour" is 45-50 minutes in duration to allow time for record keeping and administrative tasks.
10. Sessions canceled without 24 hours' notice will be charged at the regular hourly rate. To respect the time of others, sessions will conclude on time regardless of when you arrive. Exceptions may be made in the case of emergencies as the discretion of the therapist. I understand that my credit card will be charged at the time of my appointment if I have not canceled 24 hours' prior. *initial: _____*
11. Telephone contact exceeding 5 minutes will be considered a telephone therapy session and will be charged at the regular hourly rate, prorated to the length of the call. Requests for advice / feedback via email will be

- treated in the same manner. Email and texting is to be used for scheduling and administrative purposes.
12. Telephone contacts between sessions may be available as a professional courtesy. This does not constitute emergency psychological services. If you are unable to reach your therapist and feel that you cannot wait for your call to be returned, call 911 or 988, your family physician, or the nearest emergency room and ask for the psychologist or psychiatrist on call. If your therapist will be unavailable for an extended time, you will be provided with the name of a colleague to contact in the event of an emergency.
 13. To maintain the integrity of the therapeutic relationship, both client and therapist agree not to follow, send connection requests, or search for each other on social media platforms, blogs, or other personal online profiles. Engaging in such activity can compromise therapeutic boundaries, create misunderstandings, and impact the effectiveness of treatment.
 14. If you or your attorney requires that I testify in a court case, there will be a \$500 / per hour charge for time including travel, time waiting, and testimony time, as well as time required to prepare requested documents / affidavits. The role of treating therapist is distinct from that of forensic psychologist. Should you become involved in litigation or custody disputes requiring an expert psychological opinion, the court should appoint a designated forensic psychologist without prior history as your treating therapist to ensure neutrality and prevent harm or disruption to the therapeutic relationship.
 15. You may not bring weapons to therapy, regardless of permit status. Violation will result in termination.

The undersigned attests and affirms:

1. He/she enters freely into the therapeutic relationship.
2. He/she is of legal age to consent for treatment, or if a minor between the ages of 12 and 18, believes it may be harmful to self to involve parental consent and / or is a victim of abuse.
3. If parent/guardian signator, he/she has the legal right to consent for the treatment of the minor client by having full legal custody (i.e. in the case of divorced or unmarried parents). Where joint legal custody is established, both parents must sign below.

I, the undersigned, attest that I have read, understand, and agree to the terms of services described.

Signature(s) of Client(s)	Date			
Signature of Responsible Adult*	Relationship to Client			
	Date			
Signature of Responsible Adult*	Relationship to Client			
	Date			
Signature of Clinician who reviewed this information with client(s)	Date			
<i>*Responsible Adult = Guardian, Conservator, or Parent of Minor when required.</i>				
Signator <input type="checkbox"/> Declined a copy <input type="checkbox"/> Was given / downloaded a copy of this consent on	<table style="width: 100%; border: none;"> <tr> <td style="border-top: 1px solid black; width: 70%;"></td> <td style="border-top: 1px solid black; width: 15%; text-align: center;">Date</td> <td style="border-top: 1px solid black; width: 15%; text-align: center;">Initials</td> </tr> </table>		Date	Initials
	Date	Initials		
<small>This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law.</small>	Client Name: Agency: Tamar Counseling Services Clinician: Deborah Vinall, PsyD, LMFT			

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