INFORMED CONSENT

CONFIDENTIALITY:

All information shared during sessions is confidential except under circumstances governed by law (i.e. suspicion of child abuse, elder or dependent adult abuse, intent to harm self or harm another).

_____ initials

FINANCIAL AGREEMENT:

All fees are paid at time of session. I am available for phone consultations. All phone consultations lasting more than 10 minutes are charged a prorated hourly fee.

_____ initials

LATE CANCELLATION POLICY:

A full fee is charged for appointments canceled on the same day.
An $80 fee is charged for appointments canceled with only one-day prior notice.

This policy is not intended to be a financial hardship. It is merely necessary for scheduling. If payment options become necessary, please feel free to discuss this with me.

_____ initials

IN CASE OF EMERGENCY:

Your safety is very important. I may or may not be available to you in the event of an emergency. I typically check messages Mon -Sat between 8:00 am and 6:00 pm. In the event of an emergency, call 911, go to the nearest emergency room or call for a Psychiatric Evaluation Team (PET Team) at 800-479-3339. Your wellbeing is my concern. Please text or call me as soon as possible, so that I may support you through the situation.

_____ initials

STATEMENT OF UNDERSTANDING:

I am providing services to you as a marriage and family therapist. I specialize in

relationship therapy, stress reduction, mood disorders, children's behavior management, couple's therapy and insight oriented psychotherapy. If you have any questions or concerns please let me know.

_____ initials

SIGNATURES:

My/our initials above indicate that all items on this Informed Consent document have been read and understood. The signatures below indicate that questions pertaining to consent have been satisfactorily answered.

All clients please print, sign and date.

____

client 1

____

client 2

Thank you,

Marla Flores
Lead Therapist and Founder
Nurturing Solutions
MFT #35038