**Albert Modad, Psy.D.**
Licensed Psychologist #PSY29697
Tele 858-450-1101 **The Cognitive Therapy Institute, A.P.C.** 3262 Holiday Court, Suite 220
Fax 858-450-1161 A Psychological Corporation La Jolla, CA 92037

# CLIENT ADVISEMENT FORM
# (Child & Adolescent)

Albert Modad, Ph.D. is a Licensed Psychologist (#PSY29697) and is employed by The Cognitive Therapy Institute, a Psychological Corporation

The following information clarifies issues relevant to our professional contract and relationship. I will go over these issues with you again when we meet. Please let me know if any of these points are unclear to you or if you have any other questions about treatment. ***Please initial each blank space if you understand and agree with what is stated.***

## CONFIDENTIALITY

____In accordance with California law, the information disclosed by you and your child in therapy is confidential and is not released or accessible to anyone else without your written permission. By law, the following exceptions apply and may require that relevant information is given to others: 1) danger to self, or risk of suicide; 2) danger to others; 3) indications of current/recent child or elder abuse, and sometimes indications of past abuse when someone may be at risk of such abuse presently. In other rare situations (such as a court order from a judge, or as indicated below) confidentiality may be limited.

___Confidentiality within child therapy is unique. In order for children to feel comfortable discussing a range of issues, they need to know the information will not be shared without their permission. Therefore I ask that you, as your child's parent/guardian, agree that what your child discusses with me in session is confidential. I will not provide details of what your child has disclosed to me without your child's consent. I will, however, provide information about the interventions I use, skills being taught, assignments to be completed at home, and basic treatment progress.

___It is possible that some children/adolescents will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal experimentation, but at other times they may require parental intervention. If I ever believe that your child is clearly at serious risk of harming him/herself or another, I will inform you.

____ I acknowledge that I have received a copy of the Health Insurance Portability & Accountability Act (HIPAA) Notice of Privacy Practices, which informs me of my rights regarding Protected Health Information (PHI).

____ I understand that information regarding appointments, payments, diagnosis, address and telephone, and other information required for insurance billing, will be communicated to the Institute's administrative assistant and will be released to Linda Griebel and her associates at Griebel Billing Services (she can be reached at (619) 224-6343).

**In Case of Emergencies:** Please call Dr. Modad at (858) 740-4058 if there is a non-medical emergency. You may also call the San Diego Crisis Line at (800) 479-3339. For all life threatening or medical emergencies please dial 911.

## PAYMENT FOR SERVICES

____ I understand that my fee will be **$150** for each (45-50 minute) individual session or **$60** for each 90 minute group session, and that extended sessions or non-emergency phone therapy will incur an additional prorated fee. Consultations with other professionals (e.g. teachers, MD's), and preparation of letters or reports regarding your child, will also be billed at a prorated fee. I agree to pay in full for services rendered by Dr. Modad. Any checks that are returned due to insufficient funds will incur a **$25.00** return check fee.

**Albert Modad, Psy.D.**
Licensed Psychologist #PSY29697
Tele 858-450-1101 **The Cognitive Therapy Institute, A.P.C.** 3262 Holiday Court, Suite 220
Fax 858-450-1161 A Psychological Corporation La Jolla, CA 92037

____ I understand that I must make cancellations for therapy and group appointments 24 hours in advance and that for individual or couples sessions I will be charged a fee of **$75.00** for late cancellations and for missed or forgotten sessions. The late cancellation or no show fee for group therapy is **$30**. These fees are for reservation of that appointment time. (Insurance companies will not reimburse late cancellations.)

____ I understand that if I cancel appointments twice in any 30 day period, I will be required to pre-pay 50% of a session fee before scheduling the next appointment. I also understand that this pre-payment will be non-refundable, and will be forfeited if I cancel that next appointment, regardless of the reason for such cancellation.

____ I understand that any uncollected bills for services or missed appointments may result in disclosure of my name, telephone number, SS#, and address to a collection agency or small claims court. I also understand that I am responsible for any bills that my insurance does not reimburse.

TREATMENT OUTCOME: Although most clients do make significant progress in Cognitive Behavioral Therapy, there are no guarantees that treatment will be successful, The length and outcome of treatment is based on your and your child's motivation for treatment, how long your child has had the symptoms, the skill of the therapist, and other factors.

I (WE) HAVE READ AND I UNDERSTAND THE INFORMATION ON THIS AND HAVE RECEIVED A COPY OF THE HIPAA NOTICE. I (CLIENT) WILL REQUEST A COPY OF THIS ADVISEMENT FORM IF SO DESIRED.

_____ _____
Client Date

_____ _____
Parent or Guardian Date

_____ _____
Parent or Guardian Date

_____ _____
Albert Modad, Psy.D. Date