Katherine Ellis-Hernandez, PhD (PSY24263)
Clinical and Reproductive Health Psychologist

Family
Health
Psychology

Informed Consent for Therapeutic Services

Please read this document carefully so that you can make an informed decision about attending and participating in therapeutic services provided by Clinical and Reproductive Health Psychologist, Katherine Ellis-Hernandez, PhD (PSY 24263). Feel free to ask any questions before signing this document and understand your participation is completely voluntary.

Qualifications: I am licensed by the Board of Psychology (PSY 24263) in the State of California. I received my bachelor's degree in Psychology from the University of North Carolina at Wilmington and my master's and doctoral (2009) degrees in School Psychology from Fordham University in New York. I have facilitated family, group and individual counseling as well as, educational groups focusing on topics such as: relationships, HIV/AIDS education, reproduction and sexual education, and parents educating children about sexual and reproductive health.

Therapeutic Services: My orientation to the practice of psychology is solution-focused and integrates techniques from a variety of theoretical backgrounds depending on what works best for each individual. Solution-focused therapy focuses on finding positive solutions versus dwelling on problems and negative behaviors. While the initial goals for many clients are often to identify and solve problems, many of my approaches are cognitive-based allowing me to assist her clients in better understanding themselves and how they think, feel and react to the world around them. This may ultimately lead to changes in thinking and behavior that result in more self-awareness and obtaining tools to better cope with health, familial, occupational and social stressors. I believe therapy, both individual and group, is a collaboration between the client and the therapist and I strongly encourage your active participation and honest feedback. However, your participation is completely voluntary and will be based on your individual comfort-level. The therapeutic relationship and progress in meeting predetermined goals are continually evaluated as part of the process of therapy. The length of our work together will be determined as therapy unfolds and goals are identified. You can expect that I will provide guidance and give recommendations, however, I encourage my clients to actively find solutions that will fit within the parameters of their individual lifestyles and worldviews. I also encourage a holistic and multidisciplinary approach to therapy and am willing to collaborate with other health care providers treating you if appropriate and with your permission (i.e., acupuncture, reproductive medicine, psychiatry, school staff, etc.).

Appointments: My usual assessment procedure is to conduct three (3) initial consultation sessions to determine if we are well-suited and well-matched in order to meet your goals. After we agree to work together, we will set a regular meeting time. Consultative and therapeutic sessions are 45 minutes and the remaining 15 minutes will be reserved for record-keeping and any interdisciplinary communication. Once your appointment time is reserved, I require a 24 hour appointment cancellation. We will try to reschedule your missed appointment if possible. If we are conducting couples or family therapy, it is important that you understand that all members must attend all scheduled sessions together. In the event all members do not attend, you will be responsible for the payment of the session unless a 24 hour notice was provided.

Payment: The weekly fee for small group therapy is $50 per individual or $75 per couple/siblings. The fee for each individual, couple or family session is $150, and unless otherwise agreed, payment is expected at the time of service. Other professional services will be broken down by hourly costs for periods of time less than one hour that are arranged and agreed to in advance of the service. Examples of these services are report writing, extended telephone conversations, attendance at meetings with other professionals which you have authorized, preparation of records or treatment summaries, or any other service you may request. If you become involved in a legal proceeding that requires a psychologist's participation, you will be expected to pay for that time, as well as time taken away from my daily practice.

Several appointments are reserved for those requesting a reduced fee. You will retain the reduced fee for a period of three (3) months. At the end of each three month period, we will discuss your financial situation and determine if a reduced fee remains appropriate.
Once an appointment is scheduled, you will be expected to pay for the time reserved unless you provide at least 24 hours advanced notice of cancellation. Less than 24 hours is considered a late cancellation and does not allow that time to be reserved for another client. All outstanding balances must be paid before the end of the month for billing purposes. Any outstanding balances due to cancellations or missed payments must be paid within three (3) months. Therapeutic services will stop if payment is not received after three (3) months.

While I am not “in network” with any insurance companies, I will submit claims to insurance companies on behalf of my clients. Clients are responsibility for paying the fees up front, but some insurance companies will reimburse clients depending on the plan. If you would like for me to submit claims to your insurance, you must complete the Health Insurance Claims Form . Please download this form and bring a completed form along with your health insurance card to your first visit. For those who would like assistance to find out about benefits prior to the first visit, I am happy to contact your insurance company on your behalf if you send me the form and a copy of your card in advance.

Contacting Me: Although I am not often available immediately by telephone or email, I do monitor my voicemail and email frequently and will make every effort to get back to you within 24 hours, with the exception of weekends and holidays. My telephone number does not receive texts and both voice and e-mail is reserved only for scheduling purposes. Please to not include clinical content in your messages. Please understand that I do not provide 24-hour crisis intervention services. If you feel you require a therapist who will be available outside of business hours than I am likely not a good fit for you and will be happy to assist in referring you to someone who could meet your needs. For clinical emergencies, you should call 911, contact the San Diego County Crisis Hotline (800)479-3339, or go to the nearest emergency room.

Confidentiality/Privacy: In general, all communication during therapy is private. However, I may be discussing cases with other professional consultants, as needed. During these consultations, I will avoid revealing any information that may lead to you being identified. I may also bring topics of interest or general concerns to the attention of my colleagues when I feel it would benefit those in the field to provide better services, however, your anonymity will be respected and no identifying information will be shared. As a member of group therapy, you agree to maintain the confidentiality of the other members as well by respecting their privacy and not disclosing sensitive information to individuals outside of the group.

There are also several exceptions when evaluators are legally mandated under California law to break confidentiality. If there is reasonable suspicion a child, dependent adult, or elderly individual is being abused or neglected a report must be filed with the respective Protective Services agency. If it is believed you are making a serious threat of physical harm to another person or yourself, protective measures must be taken (e.g., notifying the potential victim, contacting the police or family members, and/or seeking hospitalization). During legal proceedings, written evaluations and assessment notes may be subpoenaed or court-ordered. If you sign a consent to release information to a third party of your choosing, (e.g., Authorization to Disclose Protected Health Information), disclosure of your records may also be made.

For clients under eighteen (18) years of age, please be aware that the law may provide parents the right to examine treatment records. It is my policy to request an agreement from parents that they agree to give up access to minor clients' records. If they agree, I will provide them only with general information about the treatment unless I feel there is a high risk that the minor client is facing serious jeopardy or harm. In that case, I will notify parents of the concern. Before giving parents any information, I will discuss the matter with the minor client, if possible, and process any objections the minor may have with what I will be disclosing.

Multiple Relationships: In the event that we have contact outside of the professional setting (ex: a public place or leisure event), I operate under the "you first" rule, meaning I will not acknowledge you first and will leave it up to you to disclose the extent of our relationship to others. You also understand that I provide supportive services for clients including conducting psychological evaluations, facilitating monthly support groups, and providing individual, group, and family therapy. My clients may consist of families, surrogates, egg donors, intended parent(s), agencies, and/or medical clinics. If I am working with you in more than one capacity, I will remain objective and maintain your confidentiality, however, we will need to discuss my role as your therapist and potential effects this may have on our therapeutic relationship.

This document is to inform you of supportive therapeutic services that are provided by Dr. Ellis-Hernandez. If you have any questions or concerns that were not addressed in this document, please take the time to ask and do not sign this document until you fully understand.
By signing this document you are indicating that you have read and understand the information. You have been given the opportunity to ask questions and agree to the terms described.

_____ _____
Client's Name (Print) Client's Signature/Date

_____ _____
Client's Name, if applicable (Print) Client's Signature/Date

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Clinical and Reproductive Health Psychologist _____
Signature/Date