Greg Whittaker MA, LMFT
8371 Church Street, Gilroy, CA 95020 | PHONE (408) 848-3331 | FAX (408) 848-3354

TREATMENT DISCLOSURES

Limits of Confidentiality
All information between practitioner and client is held strictly confidential. There are legal exceptions to this:

1. The client authorizes a release of information with signature.
2. The client's condition becomes an issue in a lawsuit.
3. The client presents a physical danger to him/herself.
4. The client presents a danger to others.
5. Child or elder/dependent adult abuse or neglect is suspected.

In the latter three cases, the practitioner is required by law to inform potential victims and legal authorities so that protective measures can be taken.

All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency. **INITIAL HERE_____**

Financial Terms
Fee arrangements will be made directly with the practitioner. Unless otherwise arranged, payment in full is due at the time of each session. The client is ultimately responsible for 100% of the fee. Periodically I may raise my fees. I will give you at least 30 days notice before doing so. **INITIAL HERE_____**

Insurance Coverage and Co-payments
You are responsible for obtaining prior authorization for treatment from your insurance carrier. The billing personnel will bill your insurance as a courtesy. If there is a co-payment, it is due at the time of each session. Any portion of the fee that your insurance does not cover, you are responsible to pay. **INITIAL HERE_____**

Cancellation and Missed Appointments Policy
Scheduled appointment times are reserved especially for you. If an appointment is missed or is canceled with less than **24 hours notice,** you will be billed according to the scheduled fee. Insurance plans do not pay for these fees.
INITIAL HERE _____

Emergency Access
This practitioner cannot guarantee availability after hours. He will make every effort to answer an emergency call as soon as possible. In the event of an emergency ***do not wait for his call*.** When immediate intervention is required, you can call:

Life threatening danger, **call 911** or go to your nearest Emergency Room
Crisis Line 855-278-4204
Child Protective Services 683-0601

Consent for Treatment
I authorize and request my practitioner to carry out psychological treatment and/or diagnostic procedures, which, now or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psycho-therapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me**. INITIAL HERE _____**

PATIENT SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____ DATE _____

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General consent for Child or Dependent Treatment

I am the legal guardian or legal representative of the client and on the client's behalf legally authorize the practitioner to deliver mental health care services to the client. I also understand that all policies described in this statement apply to the client I represent***. If divorced, both parents must sign consent form.***

CLIENT NAME _____RELATIONSHIP_____

SIGNATURE of PARENT/GUARDIAN _____ DATE_____

SIGNATURE of PARENT/GUARDIAN _____ DATE_____