Troy Piwowarski, Psy.D.

License #: PSY 28839

Consent to Services Agreement

By signing this form, you hereby authorize me, Troy Piwowarski, Psy.D., to administer psychological services to you. I am a licensed psychologist in the state of California (License #: PSY 28839), and I am qualified to provide psychotherapy, consultation, psychological assessment, and instruction.

Confidentiality: For therapy to be effective, you need to know that the details you may share in the course of our work together will be kept confidential. Your private information will not be released without prior written consent of either you or your legally responsible person, including the fact that you are working with me as a client. Information in your records is confidential and cannot be released without your written consent.

There are limited exceptions to your general right to confidentiality, which include a) direct communication of intent to harm yourself or an identifiable other, b) if I have reasonable suspicion that you intend to harm yourself or an identifiable other, c) in the case of a court order or emergency situation, or d) if I suspect that *any* child, elderly person, or person incompetent to make judgements for him or herself is being abused or neglected (including any mention of people not directly connected to you). I am legally mandated to break confidentiality for each of these scenarios, and will do my best to be transparent with you about doing so.

As digital technology becomes increasingly utilized for communication, please be aware that unauthorized people can relatively easily access e-mail and cell phone communication and thus, the privacy and confidentiality of such communication can be easily compromised. E-mails and text messages in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all messages that go through them. If you choose to contact me through any of these means, you do so at your own risk of your communications being intercepted by an unauthorized person.

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, you agree that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of your psychotherapy records be requested.

Payment: You are solely responsible for full session payment at or before the beginning of each session, unless we expressly agree upon an alternative payment plan. If you plan to use insurance to pay for your sessions, you are solely responsible for making any copayments each session. All payments are due at the beginning of each session so that we have an opportunity during the session to discuss any concerns regarding fees, should any arise during the course of our work together.

You are responsible for paying the full fee agreed upon in the Payment Agreement, regardless of whether you are present for your scheduled appointment. If you need to reschedule your appointment, you may do so without charge if you notify me with more than 24 hour advance; by signing this form, you agree to be charged the full fee from the Payment Agreement for any missed sessions, or sessions canceled with less than 24 hour notice. This policy insures that I avoid incurring late cancelation fees for this office space, and provides enough time to possibly schedule another client during the time.

If your account is more than 60 days in arrears and suitable arrangements for payment have not been agreed to, I have the option of using legal means to secure payment, including collection agencies or small claims court. If such legal action is necessary, the costs of bringing that proceeding will be included in the claim. In most cases, the only

information that would be released about the treatment would be your name, the nature of the services provided, and the amount due.

Sessions: One of the most important things to establish early on in psychotherapy is the degree to which my way of working and what you are looking for in therapy match. It is typical for me to meet 2-4 sessions in order to assess the nature of your concern and the degree to which I believe I can be helpful to you. During this period, I ask that you also pay close attention to how you feel about our way of working together in order to help you assess whether I would be the best therapist for you. If we mutually decide to work with one another, I typically recommend at least once a week meetings of 45-50 minutes each, though we may meet more often if we mutually decide this is warranted and feasible. I will reserve a specific time for you each week, and that will be your time unless a change is necessary. I find that having a consistent time each week provides a sense of continuity for both myself and my clients.

Contact: If you need to get in touch with me, you may call my cell phone at (510) 878-4165 at any time. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are in crisis and feel that you cannot wait for me to return your call, you should call the emergency room and ask for the psychologist on call.

In the unlikely event that problems arise that we cannot resolve together, I can refer you to other therapists for consultation, or, if you prefer, you may find one on your own. It is also your right to contact the Department of Consumer Affairs, which receives questions and complaints regarding the practice of psychology. If you have any questions or complaints, you may contact this department by calling (800) 633-2322 or by writing to the following address:

Medical Board of California

Allied Health Complaints

1430 Howe Ave.

Sacramento, CA 95825

I have read and understand all of the above statements. I hereby consent to participating in psychological services, under these terms, with Troy Piwowarski, Psy.D.

_____

Name of Participant (please print)

_____ _____

Signature of Participant (or signature of legally responsible person) Date

_____ _____

Witness Signature Date

Troy Piwowarski, Psy.D.

License #: PSY 28839

Payment Agreement

I, _____, understand that I am solely responsible for payment of psychological services from Troy Piwowarski, PsyD. I agree to pay the fee of $_____ per session, which is due at the time of service at or prior to the beginning of each session, unless otherwise agreed upon prior to time payment is due.

Therapy sessions will be 45-50 minutes long. I understand that my session time is reserved for me, and that I am responsible for paying the full agreed fee above, regardless of whether I am present for the session. If I need to cancel an appointment or re-schedule, I understand that I may cancel or reschedule a session free of charge if I do so with greater than 24 hours before the scheduled session time. If I cancel a session within less than 24 hours of the scheduled session time, I accept full responsibility for paying the full session fee. I understand that if I have questions or concerns with this policy now or at any point in time in the future, I may discuss it directly with Troy.

I have read and understand all of the above statements. I hereby consent participating in psychological services, under these terms, with Troy Piwowarski, PsyD.

_____

Name of Participant (please print)

_____ _____

Signature of Participant (or signature of legally responsible person) Date

_____ _____

Witness Signature Date

Troy Piwowarski, Psy.D.

License # PSY 28839

I acknowledge receipt of the HIPAA Notice of Privacy Practices.

_____

Name of Participant (please print)

_____ _____

Signature of Participant (or signature of legally responsible person) Date

_____ _____

Witness Signature Date

Troy Piwowarski, Psy.D.

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AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____

Client Date of Birth: _____/_____/_____

Client phone number: _____

This form will authorize Troy Piwowarski to exchange information with _____ for the purpose(s) of _____, starting on _____/_____/_____ and expiring on _____/_____/_____.

Primary contact number for other party: _____

This authorization is for full disclosure of all records related to the items noted above. These records may be disclosed unless you specify information you wish to be excluded from this disclosure.

Please explain any information you would not like to be released, should I contact this individual or organization:

_____

_____

I understand I have the right to receive a copy of this authorization (Copy requested? Yes / No)

I understand the recipient of this information may not further use, transfer nor re-disclose this information to any person or entity unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Signed: _____ Date: _____/_____/_____

Witness Signature: _____ Date: _____/_____/_____