

*Kathleen Nickerson, PhD*

LICENSED CLINICAL PSYCHOLOGIST – PSY 20446

280 NEWPORT CENTER DRIVE, SUITE 200, NEWPORT BEACH, CA 92660

## Informed Consent Form

**Purpose of Document:** The purpose of this document is to outline your rights and responsibilities as a client of Dr. Kathleen Nickerson, as well as her rights and responsibilities to you. Please review this document very carefully and feel free to ask any questions or seek clarification from Dr. Nickerson about items contained within this document. Please sign the back of this form to signify that you have read it in its entirety. You will receive a copy of this signed consent form.

**Licensure:** Kathleen Nickerson holds a Ph.D. in Psychology and has a valid license to practice as a Psychologist in the state of California (License # PSY 20446).

**Limits of Confidentiality:** All information that you disclose to Dr. Nickerson during the course of treatment is confidential and will not be revealed to anyone without your written permission (or your parents' permission if you are under 18 years old). Disclosure, however, may be permitted or required by law when: (1) there is a reasonable suspicion of child abuse or elder adult physical abuse; (2) there is a reasonable suspicion that you may present a danger of violence to others; and/or (3) there is a reasonable suspicion that you are likely to harm yourself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding. If you have any questions about the limits of confidentiality, please discuss these concerns with Dr. Nickerson prior to signing this document.

**Consultation:** To ensure the provision of high-quality and appropriate care, Dr. Nickerson consults regularly with other professionals regarding her clients. However, the client's name and other identifying information is never mentioned in such consultations. Your identity remains completely anonymous, and confidentiality is fully maintained during professional consultations.

**Records:** Your clinical file will consist of (a) legal forms, such as this form and your HIPAA notification form, (b) a record of visits and payments, (c) assessment results, (d) a communication log and copies of all electronic communications, and (e) clinical progress notes. These progress notes will contain enough information about your treatment to justify treatment and/or allow another professional to assist in or ensure the provision of quality care.

**Payment for Services:** The fee for a 50-minute session with Dr. Nickerson is \$150.00. Dr. Nickerson does offer a sliding fee scale, based on total household income, to accommodate certain individuals. The offering of a lessened fee is completely at Dr. Nickerson's discretion. If you find that you do not qualify for the sliding scale and you cannot afford the full fee, Dr. Nickerson will be happy to do one of two things for you: (1) provide you with a flexible payment plan, or (2) provide you with a list of therapists and clinics that offer low cost therapy and treatment options. You will be expected to pay for services at the end of every session, unless other arrangements have been made. Payment can be in cash, by check, or with a credit card (through Paypal.com). By signing this document and choosing to use a credit card for payment, you are granting permission for Dr. Nickerson to bill you electronically via a third party, Paypal.com.

**Insurance Reimbursement:** Depending on your insurance coverage, a portion of Dr. Nickerson's fee may be covered through your insurance plan. If you intend to seek reimbursement from your insurance company, you will be asked to pay Dr. Nickerson for treatment at the end of your session and she will provide you with a standardized superbill to submit to your insurance company for reimbursement. Please be aware that each individual's insurance coverage is different, and it is best to check with your insurance company prior to seeking reimbursement. If your insurance plan changes or does not cover Dr. Nickerson's professional services, please note that her services are rendered and charged to you; you are ultimately responsible for payment. You should also be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, and/or to your future capacity to obtain health insurance, life insurance, and/or employment. The risk stems from the fact that mental health information is entered into insurance companies' databases and will also be reported to the National Medical Data Bank. Both your insurance company's computer network and the National Medical Data Bank are vulnerable to unauthorized access.

**Managed Care and Medicare:** Dr. Nickerson is a Medicare provider. If you are covered through Medicare, you will not need to pay for services at the time they are rendered; Dr. Nickerson will bill Medicare on your behalf.

**Cancellation:** The scheduling of an appointment involves the reservation of time specifically for you, and Dr. Nickerson will wait the entire 50 minutes for you to arrive. If you are late, you and Dr. Nickerson will meet for whatever amount of

your time remains and you be required to pay for the full session. A minimum of 24 hours notice is required for rescheduling or cancellation of an appointment. Because insurance companies cannot be billed for missed sessions, please understand that if you are using insurance coverage you will always be personally responsible for paying the charges for late cancellations and missed sessions.

**Telephone Calls and Electronic Mail:** You are welcome to leave confidential voice messages for Dr. Nickerson at any time by calling 949.222.6688; you may also leave email messages for Dr. Nickerson at any time by sending your message to drkathynickerson@yahoo.com. Your message will be returned as soon as possible; sometimes within a matter of minutes, other times within a matter of hours. Electronic messages and telephone calls are not meant to take the place of an office visit. If you call or email in the evening, on a weekend, or over a holiday, Dr. Nickerson will contact you during the next business day. With respect to cellular phones, you should be aware that while Dr. Nickerson takes every precaution to ensure the confidentiality of your cellular phone call, there is the possibility that cellular communications can be intercepted and for this reason, please carefully consider whether or not you would like to communicate via cellular phone. Additionally, while Dr. Nickerson takes every precaution to ensure the confidentiality of your email messages, there is the possibility that email communications can be intercepted and for this reason, please carefully consider whether or not you would like to communicate via email. By signing this document, you consent to Dr. Nickerson's use of cellular phones and email to communicate with you; you may revoke your consent at any time by submitting a written request to Dr. Nickerson.

**After-Hours Emergencies:** Dr. Nickerson uses both a voicemail system (949.222.6688) and email system (drkathynickerson@yahoo.com) to receive messages from clients. Messages are checked frequently throughout the day, beginning at 7:00am and ending at 7:00pm, Monday through Friday, excluding weekends, holidays, and vacations. Should you experience a clinical or medical emergency outside of these hours or one that requires immediate attention within these hours, you should dial 911 or proceed to the closest emergency room and ask that any attending staff member contact Dr. Nickerson at 714.814.9424 so that she may assist with your care.

**Appearances in Court:** If you should subpoena Dr. Nickerson to court for any purpose, you agree to pay her full hourly fee for time spent preparing, traveling, and testifying on your behalf.

**Probable Length of Treatment:** Although some individuals elect to pursue long-term, open-ended treatment, many issues can be resolved in about 10 to 15 sessions, while some highly focused issues such as phobias can be resolved in about 6 sessions. You should be aware that, although anticipated otherwise, despite treatment you may not improve as quickly as you might like, you may start to improve only after treatment has ended, or you may not improve at all. The success of any treatment depends on the motivation and aptitude of the person being treated. For this reason, Dr. Nickerson can make no guarantees about treatment length or success.

**Termination of Therapy:** In a private practice such as this, treatment is entirely voluntary, and you have the right to terminate treatment at any time for any reason. If for any reason your treatment has been ordered by a third party, you will be fully informed of this. Dr. Nickerson also has the right to terminate your treatment and provide appropriate referrals to other providers if she feels: (1) you no longer need treatment, (2) you are no longer benefiting from treatment, (3) you or someone close to you poses a threat to her or a member of her family, or (4) you would be provided with better or more appropriate care by another professional. In all cases, professional therapy NEVER includes sexual conduct. If you have any questions about your rights as a consumer of psychological services, please feel free to ask Dr. Nickerson at any time. If you believe that you have been treated inappropriately or unethically by Dr. Nickerson, you can report the matter to the California Department of Consumer Affairs by calling 916.263.2699.

**Consent to Treatment:** By signing below, I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the undersigned therapist to provide such care, treatment, or services that are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment, or services at any time. By signing this client information and consent form, I, the undersigned client, acknowledge that I have both read and understood all of the terms and information contained herein. By signing below, I acknowledge that ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client/Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Client/Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Therapist: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_