A. Raja Hornstein, PsyD

1330 LINCOLN AVENUE
SUITE 310
SAN RAFAEL, CA 94901-2143

Consent to Treatment for Couples and Acknowledgement of Receipt of the Notice of Privacy Practices

Client Names: _____

_____

Consent to Treatment:

We acknowledge that we have received, have read (or have had read to us), and understand Dr. Hornstein's "Office Policies and General Information" and the "Patients Bill of Rights" and/or other information about the therapy we are considering. We have had the opportunity to discuss our concerns with Dr. Hornstein and all our questions have been answered to our satisfaction. We do hereby seek and consent to take part in treatment with Dr. Hornstein.

We understand that Dr. Hornstein will not hold confidences of one member of the therapy from the other member, but will assist us in finding a way to work toward disclosure of any secrets critical to the therapy that are brought to Dr. Hornstein by one of us in confidence.

We are aware that there are both possible benefits and risks that may result from this treatment. We understand that no promises have been made to us as to the results of treatment or of any procedures provided by Dr. Hornstein.

We are aware that we may stop our treatment with Dr. Hornstein at any time. The only thing we will still be responsible for is paying for the services we have already received. We agree that we will not hold Dr. Hornstein responsible for any of the consequences that might result if we stop treatment, for example, but not limited to, any legal consequences if our treatment was court-ordered.

We are aware that there are legal limits to the extent of the confidentiality of our treatment, for example, but not limited to, if one of us become a danger to him or her self or to others. We understand that in court proceedings, the confidentiality of our treatment may be limited. Due to the complexity of the issues that arise in treatment, We agree that neither of us will ask Dr. Hornstein to testify in a court proceeding on behalf of either of us.

We know that we must call to cancel an appointment at least 2 business days (48 hours) before the time of the appointment. If we do not cancel and do not show up, we will be charged for that appointment unless Dr. Hornstein agrees that the absence was due to cirucmstances beyond our control.

We are aware that an agent of any third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments we receive. We understand that we are fully responsible for the payment of the agreed upon fee for treatment if there is no contracted fee with a third-party payer, and that continuation of treatment is dependent on payment.

We understand that we may lodge complaints about our treatment with the California Board of Psychology or with the Ethics panel of the American Psychological Association

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CLINICAL PSYCHOLOGIST PSY21271

calligraphy
xin: heart/mind

Our signatures below shows that each of us understands and agrees with all of the statements on page 1 of this Consent to Treatment for Couples.

Signature of Client: _____

Date: _____

Signature of Client: _____

Date: _____

Acknowledgement of Receipt of the Notice of Privacy Practices:

I acknowledge that I received a copy of the current Notice of Privacy Practices of Dr. Hornstein. I am aware that Dr. Hornstein has the right to change the Notice of Privacy Practices and that any changes will apply to my records retroactively. I understand that I have a right to a copy of any changes of the Notice of Privacy Practices. I understand my right to lodge complaints about violations of the Privacy Rule of HIPAA or of Dr. Hornstein's Notice of Privacy Practices.

Signature of Client: _____

Date: _____

Signature of Client: _____

Date: _____

Therapist Agreement

I, the therapist, A. Raja Hornstein, PsyD, have discussed the issues above with the clients. I agree to conduct my treatment with the clients according to the relevant federal and state laws and to the ethics code of the American Psychological Association. I agree to protect the confidentiality of the treatment as fully as possible within the constraints of the law.

My observations of both of these persons' behavior and responses give me no reason to believe that either of these persons is not fully competent to give informed and willing consent.

Signature of Therapist: _____

Date: _____

❑ Copy accepted by clients

❑ Copy kept by Dr. Hornstein

This is a strictly confidential patient medical record.

Redisclosure or transfer is expressly prohibited by law.