THERAPEUTIC CONTRACT

Psychological Services:

Leslie Spero LCSW provides adolescent, college-age, adults, and individual and family therapy. Psychotherapy seeks to treat variety of emotional and interpersonal problems. Therapy can be a benefit to you and give you a better understanding of your personal goals and values, improve interpersonal relationships, reduce or eliminate certain psychological symptoms and to improve social, emotional, educational and occupational functioning. Unlike medical consultations, therapy proceeds by having all parties work actively to gain insight into and alter certain maladaptive emotional states and behaviors. The psychotherapeutic process varies depending on the personalities of the therapist and patient (s) and the particular problems brought forward. Psychotherapy calls for an active effort on your part. Psychotherapy can have benefits and risks. Since it typically involves discussing unpleasant aspect of your life, you may experience uncomfortable feelings like sadness, guilt, anger and frustration. On the other hand, actively participating in therapy has been shown to have significant benefits as well.

CLIENT'S RIGHTS:

You have the right to a confidential relationship with the therapist. Within certain legal limits, information revealed by you during the course of therapy will be kept completely confidential and will not be revealed to any person without your permission.

- 1. You have the right to know the content of your records at any time and I have the right to provide you with the complete records or a summary of their content. **INITIAL**____
- 2. If you request, I can release any part, or all of your records on file to any person you specify. I will tell you when you make your request whether or not I believe releasing that information to a specific agency or person might be harmful to you. **INITIAL**_____
- 3. Under certain legally defined situations, I have a legal obligation to reveal information you tell me during the course of therapy to another person or agency without your written consent. These legally define situations include:
 - A. Disclosing information regarding child abuse: physical, sexual, emotional or neglect of a minor. If there is a reasonable suspicion that he/she may be abuse. If there is a reasonable suspicion of abuse of a dependent adult or and elder adult in the following areas; physical abuse, abduction, financial abuse, isolation, mental suffering, and neglect. **INITIAL**

	B. If you seriously threaten harm or death to another person, I am required to						
	warn the intended victim and notify the appropriate law enforcement ag		warn the intended victim and notify the appropriate law enforcement agency.				
			INITIAL				
		C.	If you are in therapy by order of the court, the results of the treatment ordered				
			must be revealed to the court. INITIAL				
		D.	If a court of law issues a legitimate subpoena, I am required by law to provide				
			the information specifically described in that subpoena. INITIAL				
E. You have the right t		E.	You have the right to ask questions about any of the procedures used in the				
course of your treatment. I			course of your treatment. INITIAL				
F.		F.	The therapist may be obligated to seek hospitalization or contact others who can				
			help you if you become a danger to yourself, verbalize suicidal ideations, have a				
			plan and a timeframe. INITIAL				
	4.	You ha	eve the right to terminate therapy with the therapist at any time without any				
		financ	ial, legal or moral obligations other than those you have already incurred. I have				
		the rig	tht to terminate therapy with you under the following conditions:				
		A.	When I determine that therapy is no longer beneficial to you.				
		B.	When you refuse to cooperate with treatment.				
		C.	When I believe that another professional will better serve you.				
		D.	When you have not paid for the last two sessions, unless special arrangements				
			Have been made with the therapist ahead of time.				
		E.	When you have failed to show up for your last two-therapy session without a				
			24-hour notice. INITIAL				
	5.	If you	are a minor, please be aware that the law may provide your parents the right to				
		exami	ne your records. Your psychotherapist will typically either request that they				
	relinquish access to your records, or will provide them only with general information						
	about the treatment unless it is felt that there is a high risk that you will seriously harm						
	yourself or someone else. INITIAL						
PROF!	ESS1	IONAI	L FEES:				
The fee	is \$1	50 for	each completed fifty-minute session. I require a credit card on file. Each week				
copayment or cash payment will be charged to the credit card on file. I understand that I can leave							
therapy at any time and that I have no financial, legal or moral obligation to complete any maximum							
number of sessions. Please be aware that in order to schedule sessions in an effective matter, I							
$require\ a\ 24-hour\ notice\ of\ cancellation\ otherwise\ there\ will\ be\ a\ \$100\ missed\ session\ fee\ charged\ to$							
your card on file. Insurance companies will not pay for a missed session. INITIAL							
If you need a super bill one can be provided for you on a monthly bases which you can then submit to							
your insurance company. INITIAL							
If I'm a	prov	ider un	der your insurance plan, your credit card on file will be charged after each				
session. INITIAL							

BILLING AND PAYMENTS

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release is the client's name, nature of services provided, and the amount due. **INITIAL**

USE OF E-MAIL COMMUNICATION CONSENT:

I continue to try and improve methods of communication and convenience for my clients and use email for all forms of communication, and any confidential information. It is important to note that this type of communication is not always secure. I cannot promise security and confidentiality when receiving or sending e-mails and will not be responsible if e-mails are incorrectly shared or if someone else gets a hold of them. All e-mails sent to me will become a part of your records.

INITIAL ____

SOCIAL MEDIA:

I don't use social media in my professional services, other than my website. Leslielcsw.com. Please do not attempt to contact me through social media. I reserve the right to terminate our professional relationship if that request is disregarded. **INITIAL**

CONTACT WITH FAMILY AND CLIENT BETWEEN SESSIONS:

If there is a need to contact you in-between sessions may I:						
	Contact you by home phone					
	Contact you by cell phone					
	Leave a message on your answering machine or cell phone					
	Leave a text on your cell phone					
	Email you. If yes provide me with your e-mail					

ARBITRATION/MEDIATION AGREEMENT:

All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of the treating LCSW and client. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settle by binding arbitration in Los Angeles County, in accordance with the rules of the American Arbitration Association which are in effect at the time demand for arbitration is filed. The prevailing party in arbitration shall be entitled to recover a reasonable sum for attorney's fees, to be determined by the arbitrator. **INITIAL**

CONSULTATIONS:

It is required professional practice for a treating clinician to consult with colleagues about issues in
evaluation and treatment In such consultations, the patient's name and any other identifying
information is never mentioned. I will maintain all professional standards set forth in the ethical
principles of my professional association as well as the laws of the State of California governing the
practice of psychotherapy. INITIAL

TREATMENT PLANNING:

Early in our discussions, we will be formulating goals and objectives for the treatment of the client. These goals and objectives will be reviewed on a regular basis. You should feel free at any time to ask questions regarding your treatment, goals, and objectives. You should talk to me immediately if any of these treatment goals or objectives causes you confusion or discomfort. Please feel free to ask about other forms of treatments for your condition and their benefits and risk. **INITIAL**

TELEPHONE AND EMERGENCY PROCEDURES

Leslie Spero LCSW is often not immediately available by telephone. When I'm unavailable, the telephone is answered by voice mail which is monitored frequently. I check my messages several times per day. When I'm out of town, I will have another licensed therapist on call and that person's name and phone number will be left on my answering machine. If an emergency situation arises and you need to speak to someone immediately, you can call the suicide hotline at 988 (suicide hotline), and or the crisis services team: Los Angeles (800) 854-7772, Ventura County (805) 652-6727.

CONSENT FOR TREATMENT:							
, authorize and request that Leslie Spero LCSW, to carry out							
psychotherapeutic examinations, diagnostic procedures, and/ or treatment for							
. I understand that the purpose of any procedure will be explained to me and							
be subject to my agreement.							
ACKNOWLEDGING SIGNATURES:							
I have read and understand this Agreement, Informed Consent for Psychological Treatment and for							
Uses and Disclosures to Carry Out Treatment, Payment, Treatment Planning and Confidentiality. I							
understand and agree to comply with them.							
By signing this agreement, I am consenting to psychotherapeutic treatment:							
Print name/guardian's /parents name	Signature	Date					
Therapist Name	Signature	Date					