Misha Gutkin, PhD Licensed Clinical Psychologist PSY24794

2930 Camino Diablo, Suite 305 Walnut Creek, CA 94597

www.DrGutkin.com

Phone: (925) 276-2002 Fax: (925) 276-2006

Office Polices, Procedures & Consent to Treatment

The Benefits and Risks of Therapy: As with any treatment, there are some risks as well as many benefits with therapy. You should think about both the benefits and risks when making any treatment decisions. For example, in therapy, there is a risk that clients will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other negative feelings. Clients may recall unpleasant memories. These feelings or memories may bother a client at work or in school. In addition, some people in the community may mistakenly view anyone in therapy as weak, or perhaps as seriously disturbed or even dangerous. Also, clients in therapy may have problems with people important to them. Family secrets may be told. Therapy may disrupt a marital relationship and sometimes may even lead to a divorce. Sometimes, too, a client's problems may temporarily worsen after the beginning of treatment. Most of these risks are to be expected when people are making important changes in their lives.

While you consider these risks, you should know also that the benefits of therapy have been shown by hundreds of well-designed research studies. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. In therapy, people have a chance to talk things out fully until their feelings are relieved or the problems are solved. Clients' relationships and coping skills may improve greatly. They may get more satisfaction out of social and family relationships. Their personal goals and values may become clearer. They may grow in many directions—as persons, in their close relationships, in their work or schooling, and in the ability to enjoy their lives.

Consent to Treatment: I (the client or client's guardian) acknowledge that I have read (or have had read to me), and understand the information about Dr. Gutkin and his work presented on www.DrGutkin.com and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by Misha Gutkin, PhD. I understand that developing a treatment plan with Dr. Gutkin and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Dr. Gutkin.

Confidentiality: In general, everything about the professional relationship with Dr. Gutkin is confidential and will not be disclosed to anyone without a written permission, including the fact that you or your child is being seen for therapy or psychodiagnostic evaluation.

Under California law exceptions to this rule are the following:

- If there is a reasonable suspicion of child abuse or neglect, or abuse or neglect of an elderly or a dependent adult, a report must be made;
- Should there be a threat to harm another person, that person and the police will be informed;
- Court order
- If a client is in danger of intentionally harming him/herself or is unable to care for him/herself, apropriate help will be sought on his/her behalf.

When I am away from the office for a few days, I have a trusted fellow therapist "cover" for me. This therapist will be available to you in emergencies. Therefore, he or she needs to know about you. Of course, this therapist is bound by the same laws and rules as I am to protect your confidentiality.

Divorces/Court Testimony: If you ever become involved in a divorce or custody dispute, I want you to understand and agree that I will not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on two reasons: (1) My statements will be seen as biased in your favor because we have a therapy relationship; and (2) the testimony might affect our therapy relationship, and I must put this relationship first.

Contacting Dr. Gutkin / Emergencies: Currently, I have a small private practice since I also hold a staff Psychologist position with Kaiser Permanente. Through out the week you can contact me by calling (925) 276-2002 and leaving a message. I typically return calls within 1 business day. Please note that I do NOT provide any emergency services. If you find yourself to be in the state of a medical or a psychiatric emergency, please call 911 or go to the nearest emergency room. You can also contact Contra Costa County Crisis Line at (800) 833-2900 or (925) 938-0725.

Appointments/Cancellations: I (the client or client's guardian) know that I must call to cancel an appointment at least 72 hours (3 days) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I (the client or client's guardian) am aware that I may stop receiving the services provided by Dr. Gutkin at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive is not made, Dr. Gutkin may stop my treatment and I hold the responsibility for occurred charges.

My signature below shows that I understand and agree with all of these statements.

Signature of client (or person acting for client)	Date
Printed name	Relationship to client (if necessary)
	with the client (and/or his or her parent, guardian, or other behavior and responses give me no reason to believe that this d willing consent.
Signature of therapist	Date
☐ Copy accepted by client ☐ Copy kept by then	apist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.