



## **Informed Consent (page 1 of 4)**

**Welcome to KM Holistic Psychotherapy! Information in this packet is confidential and vital to the treatment process; we appreciate your time and consideration!**

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask Katarina Matolek, MA, LMFT #105889 any questions that you may have regarding its contents.

**Information About Your Therapist:** Katarina Matolek, MA, LMFT 105889

Katarina Matolek is Licensed Marriage and Family Therapist, License #105889

**Information About This Practice:** KM Holistic Psychotherapy. Katarina Matolek, MA, LMFT is the owner and psychotherapist.

### **Fees**

The fee for service is \$ 185 per individual therapy session.

The fee for service is \$ 250 per conjoint (marital /family) therapy session.

**Fees are payable at the time that services are rendered.**

### **Cancellation Policy**

Clients can cancel or reschedule an appointment anytime, as long as they provide 24-hours-notice. If you cancel an appointment with less than 24-hours-notice, or fail to show up, the patient be charged for the appointment.

### **Late Arrival Policy**

Your late arrival will require that I end the session at the scheduled time, meaning your session will unfortunately be shorter today. Your therapist, Katarina Matolek have reserved this time for you and only you and have other people scheduled after your time.

**Confidentiality** All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If

## Informed Consent Continues (page 2 of 4)

you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, your therapist will not disclose information communicated privately to him or her by one family member, to any other family member without written permission.) There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child, dependent adult or elder abuse. Therapists may also be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself.

**Minors and Confidentiality** Communications between therapists and patients who are minors (under the age of 18) **are confidential.** However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently,

Katarina Matolek, MA, LMFT, in the exercise of his or her professional judgment, **may** discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with Katarina Matolek, MA, LMFT.

**Therapist Availability/Emergencies** You are welcome to phone your therapist Katarina Matolek in between sessions. However, as a general rule, it is our belief that important issues are better addressed within regularly scheduled sessions. You may leave a message for Katarina Matolek at **310-500-5103** at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non urgent phone calls are returned during the therapist's normal workdays within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail. **In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.** Please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. You should be aware that your therapist is generally available to return phone calls within approximately 24 hours. Your therapist, Katarina Matolek, is not able to return phone calls **after 8PM.** Your therapist, Katarina Matolek is not is **not available to return phone calls on MONDAYS or when she is on a scheduled vacation of which you will be informed accordingly.** If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail message. **In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.** You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis:

## **Informed Consent Continues (page 3 of 4)**

### **Los Angeles County Human Services Hotline**

<http://www.211la.org>

Dial “211”

24 Hours Bilingual

### **Los Angeles County Department of Mental Health**

[dmh.lacounty.gov](http://dmh.lacounty.gov)

800-854-7771

24 Hour Bilingual

### **Suicide Hotline Prevention Number Los Angeles:**

**Didi Hirsch – Suicide Prevention Hotline**

<http://www.didihirsch.org>

877-7-CRISIS or 877-727-4747

### **National Suicide Prevention Lifeline**

<http://www.suicidepreventionlifeline.org>

24 Hour – Local Referrals

1-800-273-TALK (8255)

1-888-628-9454 (En Espanol)

1-800-799-4TTY (4889)

VETERANS PRESS “1”

### **Teen Line**

[www.teenlineonline.org](http://www.teenlineonline.org)

800-TLC-TEEN (852-8336)

### **Los Angeles Gay and Lesbian Center**

<http://www.lagaycenter.org>

323-993-7400

### **The Soldiers Project**

[www.thesoldiersproject.org](http://www.thesoldiersproject.org)

877-576-5343

### **Therapist Communications**

Your therapist, Katarina Matolek may need to communicate with you by telephone or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

**Informed Consent Continues (page 4 of 4)**

- My therapist may call me on my home phone. My home phone number is: \_\_\_\_\_
- My therapist may call me on my cell phone. My cell phone number is: \_\_\_\_\_
- My therapist may send a text message to my cell phone. My cell phone number is: \_\_\_\_\_
- My therapist may call me at work. My work phone number is: \_\_\_\_\_
- My therapist may communicate with me by e-mail. My e-mail address is: \_\_\_\_\_

Sensitive, clinical information is to be discussed over the phone or in-person as deemed appropriate by the therapist. For appropriate e-mail or text communication therapist will respond to your e-mail or text within 24 hours. Potential risks of using electronic communication may include, but are not limited to; inadvertent sending of an e-mail or text containing confidential information to the wrong recipient, theft or loss of the computer, laptop or mobile device storing confidential information, and interception by an unauthorized third party through an unsecured network. E-mail messages may contain viruses or other defects and it is your responsibility to ensure that it is virus-free. In addition, e-mail or text communication may become part of the clinical record. **You may be charged** for time the therapist spends reading and responding e-mail or text messages.

**Termination of Therapy** The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy. Your signature indicates that you have read this agreement for services carefully and understand its contents. Please ask your therapist to address any questions or concerns that you have about this information before you sign.

Name of Patient (print): \_\_\_\_\_

Signature of patient: \_\_\_\_\_

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