Doug Jameson, Psy.D.
CA license #PSY19189
510-301-2712

Informed Consent to Treatment

I give my consent to Doug Jameson, Psy.D. (hereafter Dr. Jameson) to provide me with psychological services. These services may consist of several interviews, treatment sessions, the review of various documents and records from my background, and interviews with other individuals who are familiar with me (with the client's written consent).

Risks and Benefits Statement

Taking part in psychotherapy may result in numerous benefits, including, but not limited to, decreased stress and anxiety, fewer negative thoughts and/or self-sabotaging behaviors, improved relationships, increased comfort in social and professional situations, and increased self-confidence. These benefits may require substantial effort and willingness on my part to change my feelings, thoughts and behaviors.

Dr. Jameson makes no guarantees that psychotherapy will yield any or all of the benefits outlined above. Participating in therapy may also involve emotional discomfort, including remembering and discussing painful or unpleasant events, feelings and experiences. This process may evoke strong feelings of sadness, anger, fear, and other unpleasant emotions. There may be times when Dr. Jameson challenges my perceptions and assumptions of myself and others and offers different perspectives. The issues I present may result in unintended outcomes, including changes in my personal relationships.

During this process I may find myself feeling worse before I feel better. This is generally a typical aspect of psychotherapy. Personal growth and change may be easy and swift at times, but may also be slow and frustrating at other times. I agree to discuss any concerns that I might have with Dr. Jameson throughout the course of treatment.

Confidentiality Statement

I understand that all of the information which I share with Dr. Jameson is confidential with the following exceptions:

a. If a client expresses or a client's family member reports to Dr. Jameson a serious threat to harm someone, Dr. Jameson must warn the person and notify the police.
b. If a client tells Dr. Jameson that they intend to harm themselves, then Dr. Jameson may call 911 or insist upon going to an emergency room.
c. If Dr. Jameson suspects child abuse, then he must make a report to the appropriate authorities.
d. If Dr. Jameson suspects abuse of an elderly or dependent adult, Dr. Jameson must make a report to the appropriate authorities.

I understand that in the case of a delinquent account, a collection agency may be employed to seek payment however information released to them will consist solely of session dates and account balances.

I understand that Dr. Jameson is not available 24 hours a day and in the event of a life-

threatening emergency, I must call 911 or go to an emergency room for immediate assistance.

I understand that if I choose to use e-mail to communicate with Dr. Jameson that he can not guarantee the confidentiality of those messages.

Financial Responsibility/Assignment of Insurance Benefits

I authorize direct payment to Doug Jameson, Psy.D. of any insurance or EAP benefits for services rendered. I understand that Dr. Jameson will bill my insurance. If my insurance company denies payment for any services, or if my benefits end, I will be financially responsible for all fees and charges for services rendered. I agree to pay my co-pay at the time of services rendered.

I fully intend to pay any and all charges incurred for services and there is a reasonable probability that I will be able to meet the financial obligations noted herein.

Should my account be referred for collection, I agree to pay all fees and expenses incurred. I agree to pay an additional 30% of the referred amount to cover the collection costs.

There will be an additional charge on any personal checks that are returned by the bank.

Late Cancellation/No Show Policy

Because appointments are carefully scheduled and your time is reserved for you, office policy requires that you give Dr. Jameson 24-hour notice when canceling an appointment. I understand that should I fail to do so, then I will be charged a late cancellation/no show fee of $100. Health insurance plans and EAPs never cover this charge. There are no exceptions to this policy.

Dr. Jameson will wait 15 minutes past a client's appointment time. Being late will mean that I will have to pay more than the usual co-pay for the session. Furthermore, being over 25 minutes late will mean that I have to pay the late cancellation appointment fee for the session.

I will notify Dr. Jameson of any changes in address or phone number.

Acknowledgement

I have read this carefully and agree to all terms and conditions within it. I hereby freely give my consent to be treated by Dr. Jameson.

_____ _____

Client Signature Date Doug Jameson, Psy.D. Date

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CONSENT TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Federal regulations (HIPAA) allow Dr. Jameson to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services he provides, and for other professional activities (known as "health care operations."). In most cases this refers to disclosing a diagnosis, CPT code and dates of services to the client's insurance plan or EAP. Insurance companies may request a records review and receive written progress notes from Dr. Jameson.

Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices (hereafter NPP) describes these disclosures in more detail. You have the right to review the NPP before signing this consent. Dr. Jameson reserves the right to revise the NPP at any time. If he does so, the revised NPP will be posted in the office and on his website: www.drdougjameson.com

You may ask Dr. Jameson to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment or payment however, Dr. Jameson does not have to agree to these restrictions. If he does agree to a restriction, that agreement is binding. You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation. This consent is voluntary; you may refuse to sign it. However, Dr. Jameson is permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

I acknowledge that I have received the Notice of Privacy Practices and if requested, reviewed it before signing this agreement.

_____ _____

Client's Signature Date

Name: _____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

SSN:_____ Home Phone: _____

Cell phone:_____

Emergency contact name and phone number:_____

Medication Allergies:_____

Current Medications: _____

Insurance Information:

Employer: _____ Insurance Company:_____

ID#:_____ Group #_____

Co-pay:_____ Secondary Insurance (yes/no): _____

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6097 Claremont Ave
Oakland, CA 94618
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AUTHORIZATION TO RELEASE INFORMATION

Insurance companies strongly encourage health care providers to coordinate treatment. They require Dr. Jameson to obtain consent or document the client's denial of consent.

I, _____, (hereinafter "Client") hereby authorize

Doug Jameson, Psy.D. , (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Client, including, but not limited to, therapist's diagnosis of Client, to Client's primary care physician:

_____
(Name and phone number of primary care physician)

Or

_____I decline to allow Dr. Jameson to contact my primary care physician.

_____ _____
Client's signature Date