Informed Consent for Treatment of a Dependent James M. Claiborn Ph.D. ABPP ACT
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7 W. Figueroa, Suite 300 Santa Barara CA 93101
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Specializing in Obsessive-Compulsive Disorders

This document is intended to provide you information to allow you to give informed consent for treatment with James M. Claiborn Ph.D. ABPP a psychologist licensed in the states of California, Delaware, Maine. New Hampshire, New York, and Vermont. At this time, I have offices in Maine and California and my practice will be conducted according to the rules and regulations governing the practice in the state where I and the client are located at the time of service. Please read this document carefully. Your signature will indicate your acceptance of the terms and constitute a binding agreement.

I earned my Ph.D. in psychology in 1978 from Texas Tech University. My areas of expertise include cognitive behavioral therapy and the treatment of anxiety disorders including obsessive-compulsive spectrum of disorders. My professional behavior is guided by the American Psychological Association Code of Ethics.

I will provide psychotherapy and consultation services in person or by electronic means. It is understood that I am practicing in Maine regardless of the location of the person receiving services. Psychotherapy may have potential benefits such as reducing distress and improving function in various areas of life. Psychotherapy also has risks including possibly experiencing uncomfortable emotions. There is no guarantee of any particular outcome.

All treatment will be provided by electronic means. I will be available for phone contact video conferencing or other agreed on means of communication at prearranged times and for agreed periods of time. Communications by email or other means will be responded to in a timely fashion and time involved in reading and replying to written communication will be considered equivalent to time spent in phone contact. The timing, frequency and method of contact will be based on mutual agreement.

The fee for psychotherapy or consultation services is based on units of time. The rates for services are listed in a separate "No Surprises document. Fees are payable at the time of service or in advance. The fee is the responsibility of the client/parent/guardian, and no representation is made that fees will be covered by insurance or other third party. In the case where I agree to accept insurance, fees and copays will be adjusted according to provider agreements I have with individual insurance carriers. You will be asked to sign a form consenting to release of information to the insurance carrier including diagnosis, dates of treatment, procedure codes or other information required to obtain reimbursement from the insurance carrier.

You may contact me by telephone or other agreed on means at scheduled times. I cannot provide emergency services or guarantee my availability other than at agreed on times.

I am required by law and professional standards to keep records. You are entitled to a copy of such records. There is a fee for copying, preparation of reports and similar activities.

State and Federal law govern confidentiality. Communication between a client and psychologist is considered privileged. Information about clients and records can only be released with written consent with the exceptions noted below. The written consent to release information may be withdrawn at any time. In the event of my death or disability my records will be placed in the custody of a licensed mental health professional I have designated. Electronic communications may be subject to interception and monitoring. Any violation of confidentiality of electronically transmitted information is outside of my control and the client is hereby advised that no assurance is offered or implied that communication by electronic means including cell, portable phone or email will be protected from such interception or monitoring.

Records or other information in my possession may be released in response to a valid court order. If you initiate a lawsuit or apply for worker's compensation and questions of your mental state arise you may lose the privileged status. If I come to believe that a child, elderly person, or incapacitated adult is being abused I am obligated to report this to the appropriate agency. If I come to believe that a client is threatening serious bodily harm to themselves or others or serious property damage, I am obligated to take protective action including notification of identified victims or appropriate authorities, warn family members or seek civil commitment.

If disagreements or concerns about my actions cannot be resolved by communicating directly with me you may lodge a complaint with the state board which licenses psychologists in the state where you are located.

I acknowledge that I have received and understand information about the therapy I am considering.

for_____, who is my_____,
Name of client Relationship

including potential benefits, risks, and costs, as well as information about potential benefits, risks, and costs of alternative treatments and of no treatment. I have had all my questions answered fully, and agree that I will ask Dr. Claiborn any new questions I should have in the future.

I do hereby give consent for the above-mentioned client to take part in the treatment proposed by Dr. Claiborn. I understand that developing a treatment plan with the client's therapist and regularly reviewing our work toward meeting the treatment goals are in the client's best interest. I agree to play an active role in thisprocess.

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

I am aware that an agent of the client's insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and provider(s) of any services or treatments the client receives. I understand that if payment for the services the client receives here is not made, Dr. Claiborn may stop the treatment.

I understand that I may withdraw my consent for treatment at any time.

_____ _____
Signature of person acting for client Date

_____ _____
Printed name Relationship to client

Please direct mail to 7 W. Figueroa St, Suite 300, Santa Barbara, CA 93101

To email your forms, click my email address: **anxietyshrink@gmail.com** and attach your completed forms.

Copy for file Copy for client /parent/guardian.

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