

Informed Consent for Treatment with James M. Claiborn Ph.D. ABPP

This document is intended to provide you with 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. I am a registered Telehealth provider in Florida. At this time, I have professional offices in California and Maine and My practice will be conducted according to the rules and regulations governing the practice in both the state where I am and the state where the client is 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 but are not limited to cognitive behavioral therapy and the treatment of anxiety disorders including obsessive-compulsive spectrum of disorders, and psychotic disorders such as schizophrenia and sleep disorders. My professional behavior is guided by the American Psychological Association Code of Ethics.

I will provide psychotherapy and consultation services by electronic means. 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.

When treatment is provided by electronic means I will be available for phone contact 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 or online contact. The timing, frequency and method of contact will be based on mutual agreement.

The fee for psychotherapy or consultation are based on units of time. The rate for services is listed in a separate "No Surprise" document. Fees are payable at the time of service or in advance. The fee is the responsibility of the client, 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 the release of information to the insurance carrier. This information includes 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. Specific regulations may vary from state to state, and I will abide by the state regulations that apply to your location at the time of service.

Electronic communications may be subject to interception and monitoring. I will endeavor to use secure means of communication consistent with HIPPA regulations. 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.

Your signature below indicates that you have read and agree to the terms of this agreement.

Client Signature

Date

James M. Claiborn Ph.D. ABPP

Date

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

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