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Informed Consent for Family Consultation

This document contains information about my professional services and business practices. Please print out this form, read it carefully, sign it, and return it to me prior to our consultation either by fax (305-668-5756) or by email (info@drsarahravin.com). Please feel free to contact me prior to your consultation if you have questions or concerns. Your signature on this form represents an agreement between us.

Background and Credentials

I am a Florida Licensed Psychologist (#PY 8082). My educational background includes a B.A. in Psychology from Smith College and a Ph.D. in Clinical Psychology from American University. My graduate work included training and supervised experience in psychological assessment and various types of therapy, including cognitive-behavioral therapy, psychodynamic therapy, humanistic therapy, and family-based treatment for eating disorders. I completed my eating disorders training at Children's National Medical Center – Department of Adolescent Medicine from 2004-2006. I completed my pre-doctoral internship at the University of Miami Counseling Center. I completed my post-doctoral residency in supervised private practice from 2009 – 2010, and I have been practicing independently as a licensed psychologist since 2010. I am an active member of several professional organizations, including the American Psychological Association (APA), the Association for Behavioral and Cognitive Therapies (ABCT), and the Academy for Eating Disorders (AED). I am a professional advisor for a non-profit organization called FEAST: Families Empowered and Supporting Treatment for Eating Disorders.

Consultation

Consultations are scheduled on an individual basis according to the needs and goals of the individual and his or her family. Most families come to me for consultations because their loved one is "stuck" and unable to move forward in his or her recovery, or because the family is unable to access suitable resources in their geographic area. Families who travel from other geographic areas typically stay in a local hotel for several nights during their consultation. Family members who consult with me are often looking for assistance in establishing a plan of action to help their loved one. Your particular goals for the consultation will be conveyed to me in advance of your initial meeting.

Consultations generally involve approximately 4-8 hours of face-to-face meetings with me. Your consultation may be shorter or longer than this, depending on your particular needs and goals. These meetings may occur all in one day or may be spread out over the course of several days. The first two hours of consultation will be used as an evaluation and will involve interviews with you and with your family members. You and your family members may also be asked to complete written questionnaires to assess your symptoms.

The second part of the consultation will involve collaborative meetings with you and your family to generate a written treatment plan to be carried out at home. Your treatment plan may include some or all of the following: 1.) Clarification or confirmation of appropriate diagnosis; 2.) Recommendations for seeking out certain types services; 3.) Strategies that you and your family members may carry out at

home; 4.) Agreements or contracts between family members regarding how to handle certain challenging situations, 5.) Relapse prevention planning.

Within 10 days after your consultation, I will send you a written evaluation report and a formal written copy of your treatment plan and other documents (e.g., family contracts, relapse prevention plans) we create together. With your written permission, I can communicate with members of your treatment team at home to share my insights and recommendations for your loved one's ongoing care. For complex logistical, legal, and ethical reasons, I am not able to provide treatment to families who reside outside of Florida once they have returned to their home state. In some cases, I can provide long-distance follow-up consultations to families in other states for the purpose of providing advice and guidance after our initial meeting. However, these consultations are not to be construed as "treatment" and should not be used as a substitute for face-to-face treatment with a clinician when needed.

Fees

Payment is due at the time of service. I accept checks and major credit cards including Visa, MasterCard, and Discover. If you choose to pay with credit or debit card, please complete an **Electronic Payment Authorization form**. You can download and print out this form from the "forms" section of my website and send it to me prior to our consultation. This information will be stored securely in your clinical file and may be updated upon request at any time.

My fee is $210 per hour, and consultations are billed at my hourly rate. A typical consultation involves 4-8 hours of face-to-face meetings and thus costs between $840 - $1680. I do not charge for brief phone calls, emails, paperwork, or preparation time. Once you have scheduled an appointment with me, you will be expected to pay for it unless you provide 24-hours advance notice of cancellation. **You will be charged for no-shows and for appointments cancelled with less than 24-hours' notice.**

I do not take insurance. After our consultation, I will provide you with a statement which you may submit to your insurance company. Many insurance companies provide some reimbursement for mental health services, and I am willing to complete the necessary paperwork for you to receive any mental health benefits to which you are entitled. However, you are responsible for paying my fee upfront regardless of what your insurance company decides, and I cannot guarantee that you will be reimbursed. If you wish to be reimbursed, it is important that you discuss these issues with your insurance company prior to our consultation.

Confidentiality

Confidentiality is a cornerstone of the psychologist-client relationship. The ethical standards of my profession require that our work remains confidential. This means that I cannot reveal any information about you, either verbally or in writing, to anyone else without your written permission. In general, the privacy of all written and oral communications between a therapist and client is protected by law.

There are a few exceptions to confidentiality which are summarized below:

- Child Abuse or Elder Abuse. I am mandated by law to report cases of suspected child abuse (of children and youth under age 18) and elder abuse (of adults over age 60) to the appropriate authorities. The purpose of the mandated reporting laws is to protect the public from predators, who tend to be repeat offenders.
- Suicide. If you are in imminent danger of killing yourself, I will need to breach confidentiality in order to keep you safe. This may include informing your family member(s) or taking action to see that you are admitted to a hospital.

- Homicide. If you disclose to me that you are planning to kill someone, I am required by law to inform the police, inform your intended victim(s), and inform any other necessary individuals in order to prevent loss of life.
- As mandated by law. For example, if I receive a subpoena, I may be required to submit your records as part of a legal proceeding.

These situations are relatively rare. If a similar situation occurs in your case, I will make every effort to discuss it with you fully before taking any action.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a notice of privacy practices for the use and disclosure of PHI for treatment, payment, and health care operations. The HIPAA notice is in a separate document, which is available on my website in the “forms” section. Please print out a copy of the HIPAA notice for your records. Alternatively, I can provide you with a copy of the notice at our first meeting.

Signature

Your signature below indicates that you have read this document and agree to abide by its terms during our professional relationship. Your signature also serves as an acknowledgment that you have received the HIPPA notice described above.

____
Signature   Date

____
Name (please print)