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Informed Consent for Phone 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 or by email. You are welcome 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 (2001) and a Ph.D. in Clinical Psychology from American University (2008). My graduate work included training and supervised experience in various types of therapy, including cognitive-behavioral therapy, psychodynamic therapy, humanistic therapy, and family-based treatment for eating disorders. I completed my pre-doctoral internship at the University of Miami Counseling Center, including a rotation with the Miami-Dade County Department of Human Services – Psychological Services Division. 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.

My clinical practice focuses on the evaluation and treatment of eating disorders, anxiety disorders, and depression in adolescents. The majority of my patients are pre-teens, teenagers, or college students. I am a member of the Association for Behavioral and Cognitive Therapies (ABCT), the American Psychological Association (APA), and the Academy for Eating Disorders (AED). I attend local workshops and international conferences each year in order to keep my knowledge and skills current. I serve as a professional advisor for FEAST: Families Empowered and Supporting Treatment for Eating Disorders, an international non-profit organization which provides support and information for the family members of eating disorder patients.

Consultation

I offer one-hour consultations via telephone when requested in order to provide individuals with advice and guidance regarding their treatment or a family member's treatment. During the consultation, I will ask you to provide details of your (or your family member's) history. You will have an opportunity to ask me specific questions and I will provide you with advice and guidance based upon my knowledge and expertise as a psychologist. Depending on your needs (or the needs of your family member), I may recommend a particular type of treatment or a specific treatment provider. In addition, I may make suggestions about how to facilitate your recovery or support your loved one's recovery at home. I am happy to answer any other questions you have to the best of my ability.

Prior to our consultation, you are welcome to provide me with relevant documents, including growth charts, medical records, psychological testing reports, evaluations, discharge summaries, or anything else that you believe may be useful to me. If you plan on providing such documents, I ask that you send them

at least 48 hours prior to our consultation so that I may have sufficient time to review them. You may send the documents to me via fax at 305-668-5756 or email at info@drsarahravin.com.

By providing you with a phone consultation, I am not entering into a therapist/patient relationship with you or your family members. I am not providing treatment to you or to your child. Our professional relationship ends once the phone consultation is over. However, you are welcome to contact me by email afterwards if you have follow-up questions. You may also contact me again in the future if you wish to schedule a second or third phone consultation.

Fees

A one-hour phone consultation costs $210. Payment is due at the time of the consultation. 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 via fax or email prior to our consultation. This information will be stored securely in your clinical file. If you wish to pay by check, you may mail a check to my office prior to our consultation. Checks should be made out to "Dr. Sarah Ravin."

Confidentiality

The ethical standards of my profession require that our phone consultation remains confidential. This means that I cannot reveal any information about you or your family members, 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.

Signature

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

_____ _____

Signature Date

_____ _____

Name (please print) Date of Birth