

AMANDA LOMANOV, PSY.D.

Psychological Assistant (PSB94024291)
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Consent for Psychotherapy

NAME: _____

ADDRESS: _____

CITY: _____ ZIP: _____ DATE OF BIRTH: _____

PRIMARY PHONE: (____) _____ SECONDARY PHONE: (____) _____

E-MAIL: _____

EMERGENCY CONTACT NAME: _____ PHONE: _____

I am pleased to be working with you and hope that this information will help you make an informed decision regarding my services. If you have any questions at any time, please do not hesitate to ask.

Process of Psychotherapy

The purpose of our work together is to help you live a healthier, happier, and more meaningful life. I encourage you to be a proactive part of your treatment. This is achieved through the process of being open and honest about your thoughts, feelings, and life experiences, even though at times this may be difficult. Most individuals who engage in psychotherapy benefit from the experience. Therapy can lead to a decrease in emotional distress, an enhanced sense of self, healthier relationships, more positive emotions, resolution of a specific problem, and/or an overall increase in your well-being and quality of life.

It is important to acknowledge that psychotherapy has both benefits and risks. Processing your feelings, recalling life experiences, and learning about yourself can be challenging. For some people, this may bring up uncomfortable feelings, such as sadness, anxiety, fear, or anger. These feelings are a normal response to the therapy process and are typically temporary. I will make every effort to identify and discuss each of these situations as they occur, and you are encouraged to ask any questions or make suggestions regarding your therapy as we go along.

In your treatment, we will work together to foster self-understanding and personal growth, to get through difficult times, and to help you meet your personal goals. Successful therapy requires commitment, motivation, effort, and a desire to change. The work that is needed in order to see these changes will occur during our sessions, but also in your life between our sessions.

Our first few therapy sessions will be used to obtain detailed information and to make initial impressions as to what our work together might entail. During this time, it is important that you evaluate if I am a good match for you as your therapist. Your therapist should be someone who you feel connected to and safe with. Sometimes starting this kind of emotional work with someone new can bring up strong positive and/or

negative feelings. I encourage you to bring these experiences up in the therapy space as it can be a very productive part of our work together. If after several sessions you feel that we are not the best match, I will try and help you find another therapist who may be better able to meet your needs.

I only take clients that I believe I can help, and I enter the therapy relationship with optimism about working together. If you have concerns about your progress or the course of therapy, please do not hesitate to discuss this with me. You may end therapy at any time; however, it is highly recommended that we discuss termination together before therapy ends.

Confidentiality

All information regarding you, your care, and the fact that you are receiving care from me is confidential and is not released to anyone without your written consent, except when required by law. These exceptions include: (1) a situation of potential harm to yourself or others, (2) when the court demands records, (3) in cases of suspected child or elder abuse or neglect, and (4) if your insurance company requests your records. To provide you with the best treatment possible, it may also be necessary for me to discuss your case with colleagues from time to time. Those individuals are bound by the same rules of confidentiality as I am, and I will make every effort not to disclose identifying information in such situations.

Confidentiality with Children and Adolescents

When working with children or adolescents under the age of eighteen, the law may provide the parents with the right to examine their child's treatment record. However, it is my policy to request an agreement from the parents to give up access to this record, in order to allow for the best possible treatment for their child. It will be important for parents or guardians to be actively involved in their child's therapy treatment and may be asked to participate in various capacities (e.g., individually, with the child, with another relative) as determined by the needs of the child. I will provide the parents with only general information about my work with their child, unless I feel there is a risk that the child is in danger of hurting themselves or someone else, in which case I will notify the parents of our concern. In most cases, before discussing any information with the parents, I will share with the child what we intend to share with their parents, or involve the child in the process of sharing important information.

Confidentiality in Couples and Family Treatment

In couples and family treatment, you should be aware that information shared during sessions may be disclosed to the other member of the couple or other participants in treatment. A disclosure of this nature may occur when the information is relevant to the treatment in which all parties are participating, and every effort to advise you of the necessity to disclose this information will be made.

Session Time

The standard session time is 50 minutes. If you are late, we will end on time. If I am late, you will still receive your full 50 minutes for the session. This time may be provided at the end of that session or during a future session depending on what we decide together.

Fees and Payment

My fee is \$175 per session for individuals and \$200 for couples and families, with payment to be made weekly (at time of service). Please make checks payable to my supervisor, Allyn Rodriguez, Psy.D. Clients are personally responsible for the fee for service. If you wish to submit for out-of-network benefits for insurance, please speak with me and I will provide you with the necessary paperwork.

Cancellation Policy

I consider our meetings very important and expect you do the same. However, there may be times in which you need to cancel a session. In the event that you are unable to keep an appointment, please notify me immediately. If you miss a session without calling, or give less than 24 hours notice for a cancellation, you will be charged full fee for the missed appointment. If you are using insurance, insurance companies do not reimburse for missed appointments, therefore, you will be responsible for the fee if you miss an appointment or do not give 24 hours notice.

Supervision

I am currently registered as a psychological assistant (registration number: PSB94024291), which means that I am in the process of accruing my final 1,500 hours of post-doctoral training prior to obtaining licensure. I am working under the supervision of Allyn Rodriguez, Psy.D, Licensed Clinical Psychologist (PSY 27459). She can be reached at (504) 408-1762 or doctorallyn@allynrodriguez.com.

Emergencies

To contact me, please call **(914) 230-8097**. I will return your call as soon as possible, but may not be able to do so until the next business day. Because I often retrieve messages remotely, it is important that you leave your phone number so I can return your message promptly. If you are in crisis, especially if you think you may harm yourself or someone else, go to the nearest hospital emergency room or call 911. You can also call **The LA County Mental Health Crisis line at 1-800-854-7771**, where a crisis worker will be able to assess your situation and recommend the best way to help.

Please feel free to discuss any questions or concerns you may have with this consent form. You are not obligated to sign this form, and have the right to not do so. Your signature acknowledges that you have read, understood, and agree to abide to the terms of this document.

I have received a copy of and have read the Consent for Psychotherapy with Amanda Lomanov, PsyD. I have received satisfactory answers to any questions I had pertaining to its contents. I accept the terms set forth in this Agreement.

Signature of Client _____
Date

Signature of Parent or Guardian
(If client is under age 18) _____
Date