Cognitive Behavioral Therapy Services

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Client Advisement for Exposure Treatment

Chris Tammariello, L.C.S.W. is a Certified Cognitive Therapist (#LCS19544) has been licensed to practice in California since 1999 and is the Director of this practice. The following information clarifies issues relevant to the professional relationship, risk and contract between you (patient) and your therapist. The items will be reviewed with you by your therapist. Please inform your therapist if any of these points are unclear to you or if you have any other questions about treatment. ***Please initial each statement to acknowledge that you understand and agree with what is stated.***

Exposure treatment does have risks that are beyond the control of your therapist. CBTS and Chris Tammariello cannot be held liable for <u>any/all potential environmental dangers</u> or <u>any/all damages</u> that may occur before, during or after your therapy session which also include any/all dangers or damages that may occur due to the actions of the signed patient, or others. _____

____ *I acknowledge that I will use my insurance (personal, automobile) to place claims to cover any damages, injury to self or others that may have occurred before during or after the session.*

____ I acknowledge that I can stop at any time during this treatment without question.

____ I understand that even if sessions are held outside the office, my therapist will be providing me the same services, with the same rights and protections provided to me as a therapy client.

____ If sessions are held outside the office, I consent to have my therapist be in public with me. However, confidentiality will be a priority but may not be absolute.

____ I understand that I may experience anxiety and fear, which is the purpose for this treatment, but will not be put in a situation against my will, nor exposed to danger beyond what is experienced by anyone in their day-to-day life.

____ I agree to sign any Release of Information needed so that my therapist can consult with other healthcare professionals from whom I currently receive services.

____ I acknowledge that my therapist may ask me to engage in specific exercises or activities that I have been avoiding due to the sensations or fear I experience while doing them.

__ I have been informed that I can stop at anytime, but will be either encouraged to continue or provided a more appropriate strategy to cope with my discomfort or fear.

____ I understand and accept that I will be charged for my therapist's time which includes travel time. Each 50mins will incur a 160.00 charge. Any additional time will be prorated at 160.00/50mins. My insurance may not reimburse for sessions outside of the office.

____ I understand that I must make changes/cancellations for therapy appointments **<u>24 hours in advance</u>** and that I will be charged a fee of **<u>$80/hr</u>** .

TREATMENT OUTCOME: There are no guarantees that treatment will be successful, although most clients do make significant progress. The length and outcome of treatment is based on your motivation for treatment, how long you have had the symptoms, the skill of the therapist, and other factors.

I (WE) HAVE READ AND I UNDERSTAND THE INFORMATION ON THIS PAGE (PLEASE PUT INITIALS IN EACH STATEMENT ABOVE). I (CLIENT) WILL REQUEST A COPY OF THIS ADVISEMENT FORM IF SO DESIRED.

_____ _____ _____ _____

Signature of Patient Date Chris Tammariello, L.C.S.W. Date