**Abbie Zimmerman, LCSW**

License #27396

1500 Market Street

San Francisco, CA 94102

(415) 378-0534

**Informed Consent**

Welcome to my psychotherapy practice, I hope I can help you meet your therapy goals. I am an LCSW (Licensed Clinical Social Worker) and have been in private practice since 2007. I have received thousands of hours of supervised training and consultation and Licensed by the State of California. I work with individuals and families and my areas of expertise are healing from trauma, PTSD, depression, anxiety, major life transitions, relationship challenges/boundary setting and LGBTQ and gender issues. I use an eclectic approach that is client centered which includes modalities such as Psychodynamic, CBT and EMDR. I have had extensive training on all of these modalities. If there is a particular modality that you are comfortable with or one you are seeking specifically please discuss this with me. If I cannot meet this specific need I am happy to refer you to my network or a colleague for the service you are looking for.

**Appointments:** Appointments are generally scheduled one per week for 50 minute sessions. More frequent sessions can be discussed if needed.

**Fee and Payment:** I do not take insurance at this time. My sliding scale fee is $85-$120 per session. Cash is the appreciated form of payment and must be made at the beginning of every session.

**Cancellations and Missed Appointments:** I expect a 24 hour notice to cancel or reschedule an appointment. If 24 hour notice is not provided, you will be responsible for the full appointment fee. If you come late to a session we will still end at the original time scheduled.

**Telephone Contact:** If you need to reach me between appointments, you can leave a message on my voice mail at (415)378-0534. I will return your call as soon as I am able. I do not charge for brief scheduling or check in calls. Phone consultations of a half-hour or more will be charged at the usual rate. I will inform you if I will be out of town and not able to be reached. If this occurs, I will provide you with a backup therapist that can assist you in case of an emergency. Please call 911 if you are having a medical emergency.

**Confidentiality:** All information disclosed during therapy sessions and records are confidential and may not be revealed to anyone without your specific written permission, except where disclosure is required by law. In this case you will always be notified of disclosure.

Disclosure is required in the following circumstances: 1. When there is reasonable suspicion of child or elder/dependent abuse or neglect. 2. When there is reasonable suspicion that a client poses a danger to him/herself or to another person unless protective measures are taken. 3. If the disclosure is ordered by a court of law.

**Risks of Therapy:** In the process of exploring personal issues in therapy, you may experience unpleasant and painful feelings. Generally, these experiences are time-limited and can be a necessary part of the healing process. Therapy may contribute to shifts in your outlook and behavior which may impact your personal and professional relationships in unforeseen ways. These risks should be weighted with the substantial potential benefits of engaging with the therapeutic process.

**Ending Therapy:** The decision to end therapy is frequently a mutual decision, based on the work that has been accomplished. In the event that circumstances require a sudden decision to end therapy, it is my policy and preference we meet for at least one termination session to provide closure to the therapy process. Termination sessions provide an opportunity to assess the work that has been done, discuss future options and provide any relevant referrals. It is my belief that this termination session allows for an ending that protects the therapeutic work that has been accomplished.

I encourage you to ask any questions that come up for you and provide any feedback to me that can help me to support you best. There might be a style or scope of practice that is in my ability to accommodate, or possibly another therapist might be more suitable. It is your right to terminate therapy at any time without liability as long as your payments have been made in full. I also hold the right to terminate treatment without liability if I believe my scope of practice cannot accommodate your needs.

Please sign below to indicate that you have read and understand the above information and consent to treatment.

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Signature Date

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Printed Name

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best phone numbers to reach you:

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(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency please contact:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_