Informed Consent

Eugene Kranz, Ph.D. CA PSY Lic #: 23155

CONFIDENTIALITY

All information between provider and patient is held strictly confidential unless:

1. The client authorizes release of information with his/her signature.
2. The client presents a physical danger to self.
3. The client presents a danger to others.
4. Child/elder abuse/neglect are suspected.

In the latter two cases, I am required by law to inform potential victims and legal authorities so that protective measures can be taken.

5. **COUPLE'S CONFIDENTIALITY**: If a couple wishes to meet with Dr. Kranz both individually and as a couple each person understands the following:
   - There is a **"no secrets agreement"** i.e. each individual waves their confidentiality when they are in a couple's counseling session.
   - Dr. Kranz will not be called upon to testify on behalf of either member of the couple if they should become **adversarial** (for example: in a child custody proceeding).

FINANCIAL TERMS

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for you and I will be paid directly by the carrier. You will be responsible for any applicable deductibles and co-payments. Co-payments must be paid at the time services are rendered. If you are not eligible at the time services are rendered, you are responsible for full payment.

CANCELLED/MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled with less than **forty-eight hours notice**, you will be billed directly for the scheduled fee or according to the rules of your health plan. Your health plan does not cover payment for missed appointments; therefore, you are responsible for payment in full. My regular, full payment rate is $175 per 55 minute session. _____ (Initial here)

EMERGENCY PROCEDURES

If you need to reach me between regularly scheduled appointment times for **non-emergent** matters, you can call me at (805) 748-3055. The voicemail at this number is confidential. I check these messages regularly and will return your call at my earliest possible opportunity. Or, you may also reach me via email at drgenekranz@gmail.com . I check my emails regularly and will respond as soon as I am able to. Email communications should only be used for **non-emergent** matters. Non-emergent matters include things such as canceling or rescheduling appointments. For all emergencies and/or life threatening matters, please call 911 or go to your nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

RELEASE OF INFORMATION

I authorize the release of information regarding my care to my health plan for payment of claims, certifications/case management decisions, and other purposes related to the administration of benefits of my health plan.

TELEHEALTH
I have discussed the risks and benefits of engaging in online video or telepsychotherapy and/or telecoaching with Dr. Kranz. I agree to take care of myself and will contact emergency services in the event I'm in crisis or am a danger to myself. Dr. Kranz uses Zoom for Telehealth.

CONSENT FOR TREATMENT
I further authorize and request that my treating provider carry out coaching and/or mental health examinations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purposes of these procedures will be explained to me upon my request. I also understand that while the course of coaching or counseling is designed to be helpful, it may at times be difficult and uncomfortable. If I engage in **somatic therapeutic techniques** (e.g. movement therapy, breath work, gestalt therapy, etc.) I agree to keep myself safe.

I understand and agree to all the above information.

_____

Client (or Parent/Guardian) Name—Printed Date

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Client (or Parent/Guardian) Name—Signature Date