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CENTER FOR COGNITIVE THERAPY  
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## CONSENT FOR TREATMENT

**Welcome Statement:** Welcome to my office. As a licensed psychotherapist I am governed by various laws and regulations and by the code of ethics of profession. The ethics code requires that I make you aware of specific office policies and how these policies may affect you. Some of these policies will be unrelated to our work together.

**Patients' Rights:** Our relationship is strictly voluntary and you may leave the psychotherapy relationship anytime you wish.

**Limits of Confidentiality:** Sessions between a psychotherapist and patient are strictly confidential except under certain legally defined situations involving risk of self-harm or harm to another, situations of child abuse, elder abuse, abuse of dependent adults or where required pursuant to a legal proceeding. In the case of danger to others, I am required by law to notify the police and to inform any intended victim(s). In the case of self-harm, I am ethically bound to inform the nearest relative significant other, or to otherwise enlist methods to prevent self-harm or suicide. In instances of child abuse, elder abuse or dependent adult abuse. I must notify the proper authorities. When disclosure is otherwise required by law.

**Payment:** Payment is due at the end of each session. My fee is \$345.00 per 45-minute session. Please notify me if any problem arises during the course of your therapy regarding your ability to make timely payment. I reserve the right to periodically adjust this fee. I will give you prior notice of fee increases. In addition to my fee for sessions, I charge for other professional services such as report writing, telephone conversations lasting longer than 10 minutes, attendance at meeting with other professionals, preparation of records or time spent providing any other professional service requested by patients.

**Phone Accessibility and Emergency Procedures:** If you have an emergency and need immediate assistance, please call 911 for help, I am not able to provide 24-hour availability. I will return calls as soon as possible should you need to speak to me between sessions or outside of regular business hours. My cell phone number is provided on my answering machine so that I can be reached after

working hours or on weekends for urgent matters that cannot wait until the next business day. However, I cannot guarantee an immediate return call when paged. In the case of a cell phone or answering machine failure. I may not know you are trying to reach me and you may need to make a second call or page. Efforts are made to return calls within four hours. In the event of a lengthy telephone session (longer than 10 minutes), you will be charged at the hourly session fee.

**Cancellation Policy:** A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than twenty-four (24) hours' notice, you will be billed according to the scheduled fee.

**Delinquent accounts:** Payment is expected in full at each visit. If your account becomes delinquent (past 30 days) our office will begin collection procedures. We will attempt to contact you directly. However, if your account remains delinquent, we may utilize the services of an outside collection agency we may retain an attorney, or small claims court action may be taken.

**Litigation Charges:** If I am required to attend a deposition, hearing or any other legal proceeding in the capacity of your current or past therapist, you will be billed at \$500.00 per hour for my time, including preparation and travel time as well as the time I spend at the legal proceeding. If you are a current or past client, my testimony will not include any forensic opinions.

**Email or Texting:** Other than scheduling appointments, I will not accept, review or respond to emails or texts from you or someone on your behalf. Please limit email or text communication to scheduling only.

**Termination Of Therapy Services:** I may terminate therapy services at my discretion. I may consider terminations if:

- I do not believe that I can provide you with effective treatment.
- Your needs are outside the scope of my experience or training
- You desire to terminate or we mutually agree it is time to terminate treatment
- You fail to comply with treatment recommendations.
- A conflict of interest develops.
- You fail to pay my fee on a timely basis.
- You or I believe it is in your best interest.

If either you or I decide to terminate therapy services, I will recommend at least one closure session.

**Address Changes:** Please notify me immediately if you change your address or telephone number.

I, \_\_\_\_\_  
authorize and request that Mark E. Oakley, Ph D. provide psychological examinations, treatment and/or diagnostic procedures which now, or during the course of my care as a patient, are advisable. The frequency and type of treatment will be decided between Dr. Oakley and me.

1. I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.
2. I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur.
3. I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy, as the process can sometimes be uncomfortable.

I have read and fully understand this Consent for Treatment form.

Date: \_\_\_\_\_ Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Parent / Guardian: \_\_\_\_\_