Deborah Serani, Psy.D.
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INFORMED CONSENT FOR TREATMENT IN-PERSON

Welcome to my practice. Together we'll work in sessions to deepen insight and build on your strengths. Whether you're here to reduce symptoms of anxiety or depression, deal with trauma related issues or move through a difficult challenge, psychotherapy will give you the tools to understand your past, your present, and help you look forward to a meaningful future. Please read and sign this form, which will help you to learn how the collaborative experience of psychotherapy works.

Understanding Psychotherapy

I understand that psychotherapy provides professional mental health treatment interventions and support to individuals address personal, emotional, behavioral, and relationship challenges.

I understand that individual sessions are geared to meet my unique needs and that the orientation of psychotherapy with DEBORAH SERANI, PSY.D. will utilize a psychodynamic, insight-oriented modality.

I understand that the frequency of sessions (weekly, biweekly, monthly, etc.) will be a collaborative decision between DEBORAH SERANI, PSY.D, and myself.

I understand that psychotherapy services with DEBORAH SERANI, PSY.D. are in-person or may be available through HIPAA complaint telemedicine platforms.

Confidentiality

I understand that information shared during psychotherapy sessions both in-person and via telemedicine will remain confidential and won't be revealed without my written permission, except in the situations described in the HIPAA form (previously signed) ___ (initials)

Risks and Benefits of Psychotherapy

I acknowledge that psychotherapy with DEBORAH SERANI, PSY.D, strives to

- Enhance my emotional and psychological well-being.
- Offer deeper insight into my life narrative, personal issues and concerns.
- Help me develop adaptive coping strategies and problem-solving skills.
- Improve relationships and communication abilities.

I acknowledge that psychotherapy with DEBORAH SERANI, PSY.D. may also

- Give rise to emotional discomfort or distress when addressing sensitive topics.
- Change relationships in my life due to personal growth and increased self-awareness.
- Require me to adjust my expectations of what psychotherapy can and cannot achieve.
- Require additional allied medical or health related consultations or referrals

Fees and Appointments

I understand that fees for services rendered are to be paid at the time of each appointment unless prior arrangements have been made. I agree to adhere to the cancellation policy and understand that missed appointments may incur charges.

Confidentiality

I acknowledge that all information shared during sessions will be kept confidential as per HIPAA standards, except in cases where disclosure is required by law or in emergency situations.

Availability and After Hours

I understand that DEBORAH SERANI, PSY.D. may have limited availability outside of scheduled appointments. I agree to contact them during regular office hours unless it is an emergency situation, in which case I will follow the instructions provided for after-hours support.

Emergencies

I understand that in the event of a mental health crisis or emergency, I should contact emergency services or go to the nearest emergency room if I cannot successfully contact DEBORAH SERANI, PSY.D. I acknowledge that she may not be available 24/7 and agree to seek alternative emergency attention if needed.

Additional Rights and Responsibilities

I understand that I have the right to ask questions, express concerns, and be involved in decisions regarding my treatment. I agree to actively participate in the therapeutic process and communicate openly with DEBORAH SERANI, PSY.D.

Patient Name_____ Date _____

Patient Signature _____