

Marijane E. Ward, Ph.D.

901 Dove Street Suite 299

Newport Beach, CA 92660

949.388.3741

Statement of Policy

The following are policies and procedure that require your attention and will allow us to proceed with the more important aspects of yourself and your treatment .

Payment of fee: It is customary that payment be made at each appointment. If that is not possible, please make arrangements prior to the session. **Initial Here** ____

Appoint Cancellations: If an emergency arises and I need to cancel an appointment I will give a 48-hour notice. If that is not possible, you will receive the next session free. I expect as well, that you will give me a 48 hour notice if you need to cancel, otherwise you will be responsible for the regular missed appointment. **Initial Here** ____

Length of Session: Each session will be 50 minutes. This allows me 10 minutes to do paperwork and return calls. **Initial Here** ____

Messages: You will be leaving messages on a confidential voice mail heard only by me. If you do not receive a return call in a timely manner, please do call again. **Initial Here** ____

Emergencies: In case of an emergency, Please dial 911 or go to your local Emergency Room. In the event I am out of town I will always have a therapist to cover. **Initial Here** ____

Returned Phone Calls: At times it may be necessary to have phone contact between sessions, calls up to 15 minutes are at no charge. Calls longer in duration will be Charge at a percentage of your session fee. **Initial Here** ____

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Confidentiality: Communication in therapy is confidential. There are several exceptions: When there is concern for physical or sexual abuse of children or elders; Or Intent to harm self and/or others. In these circumstances, I am required by law to contact the appropriate authorities so that protective measures can be taken. **Initial Here** ____

HIPPA: Separate form included. Please acknowledge that you have received the Notice of Privacy regarding the practices of Marijane E. Ward, Ph.D. **Initial Here** ____

Consent for Treatment

I authorize **Marjane E. Ward, Ph.D.** Clinical Psychologist #16623 to diagnose and provide treatment. I understand that treatment while meant to be helpful, may also include unpleasant feelings such as sadness, anxiety and anger. These are normal responses to working through difficult emotional issues. If I have any questions, conflicts or concerns I am free to discuss them. I agree to proceed with treatment and know I can rescind my authorization at any time during the treatment process.

I have read and understand the above information and consent to treatment.

Name _____ Date _____