*Laura L. Steele, PsyD*

*265 S. Randolph, STE 250, Brea, CA 92821*

**INFORMED CONSENT**

**Therapeutic Process:**

Any counseling/psychotherapy may involve the risk of remembering unpleasant events and can arouse intense emotions of fear, depression, anger, and/or guilt/shame. Also, feelings of anxiety, frustration, loneliness, and/or helplessness may also be aroused. The benefits of counseling/psychotherapy may be that you will be better able to cope, make better choices, and /or exhibit healthier behaviors. Also, you may be able to have better relationships within your family, marriage, work, and/or other social relationships, thus experiencing more satisfaction from those relationships and in your life. Another possible benefit may be a better understanding of your personal goals and values: this may lead to a greater maturity and growth.

**Prescription of Medications:**

You should know that a Clinical Psychologist is not a physician and cannot prescribe medications. A Clinical Psychologist cannot likewise provide you with medications, nor can he/she perform any medical procedures. If medication and/or medical treatment is indicated, I can recommend a physician (MD) or psychiatrist (MD) for you or you can choose any physician/psychiatrist you wish to see.

**Treatment of Minors:** A child/adolescent will benefit most from counseling/psychotherapy when his/her parents, guardians or other caregivers are supportive of the therapeutic process. Counseling/psychotherapy is a process in which therapist and client/patient, and sometimes (when deemed necessary) other family members, discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so that the child/adolescent can experience his/her life more fully. It provides an opportunity to better understand oneself, as well as problems or difficulties he/she may be experiencing. Our work together is an important choice in your child/adolescent’s life. It requires a commitment of time, energy, and money. I welcome your questions about my work to help you make the best choice to support your child/adolescent’s needs. Please be aware that confidentiality must be protected for the therapeutic process to work. California confidential laws adhere to minors as appropriate and full confidentiality laws adhere to minors 12 years and older.

**Confidentiality**

The information disclosed by client/patient is generally confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law (SEE **“NOTICE OF PRIVACY PRACTICE”** WITH THIS PACKET OF OFFICE FORMS). Initials\_\_\_\_\_\_\_\_

**Exceptions to Confidentiality**

Laura L. Steele, PsyD is a mandated child and elder abuse/neglect reporter by the State of California and must report any suspicion or reported **child** **or elder abuse/neglect** to the appropriate authorities.

As of January 1, 2015, California Law AB 1775 required all mandated reporters to report any persons “*…who knowingly develops, duplicates, prints, downloads, streams, accesses through any electronic or digital media, or exchanges, a film, photograph, video…in which a child is engaged in an act of obscene sexual conduct.”*

Also, as a mandate reporter, clients at risk of harming self (suicide) or others (homicide), will be reported for psychiatric crisis intervention to the appropriate authorities to protect self and others from harm. Initials\_\_\_\_\_\_\_\_

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If you wish to receive psychotherapy/counseling, consultation, or coaching from Jocelyne R. Shiromoto, MSW, LCSW, please sign your name below.

**PRINT Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE of Client/Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(IF CLIENT IS A MINOR):

**Signature of Mother/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Father/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_**