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Dr. Jessica Lief
LCSW, MLS, DSW
LCSW #87286 (California)

INFORMATION FOR CLIENTS

To assist you in understanding the nature of our work together, the following is a summary of guidelines and policies for my practice.

INFORMED CONSENT FOR THERAPY SERVICES:

GENERAL INFORMATION

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Please feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

THE THERAPEUTIC PROCESS

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

CONFIDENTALITY

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.

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3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person or dependent adult who may be subjected to these abuses.
5. Suspected neglect of the parties named in items (3) and (4).
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally, I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

I am agreeing that I have read, understood and agree to the items contained in this document.

CLIENT SIGNATURE: _____ DATE: _____

THERAPIST SIGNATURE: _____ DATE: _____

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CONFIDENTIALITY OF RECORDS AND HEALTH INSURANCE

I feel strongly about the importance of being able to trust that what we discuss in therapy is confidential. Your legal rights regarding confidentiality are important to our work. My commitment to policies and practices have been in place since 2018 and will extend through the completion of our work together. I will not disclose anything from our sessions with anyone except my clinical consultant. If I need to disclose information with any other party, I must obtain your written permission to release that information, including psychotherapy notes, except where disclosure is required by law. The law requires that confidentiality be severed if I suspect that someone might be in danger of being harmed, of harming oneself, or in situations where there is suspicion of child abuse, elder abuse, or dependent adult abuse. Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain psychotherapy records.

Disclosure of confidential protected health information may be required by your health insurance carrier or HMO/PPO/EAP in order to process the claims. If you instruct me only the minimum information will be communicated to the carrier. I have no control or knowledge over what insurance companies do with the information submitted or who has access to this information. Please be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance. I would certainly inform you if I became aware of a data breach. The risk stems from the fact that mental health information is entered into large insurance companies' databases, including National Medical Data Bank, Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to unauthorized access.

EMERGENCIES

If there is an emergency during our work together, or in the future after termination where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving appropriate mental health care, I will do whatever I can, within the limits of the law, to prevent you from injuring yourself or others, and to ensure that you receive the proper medical care.
For this purpose, I may also contact the person whose name you have provided on the release form as your emergency contact.

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TELEPHONE ACCESSIBILITY

If you need to contact me between sessions, please call or leave a message on my voicemail or text me. I am often not immediately available; however, I will attempt to return your call within 24 hours. If an emergency situation arises, please call 911 or any local emergency room.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule/show for an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

CANCELLATION POLICY

It is useful to establish a regular meeting time for appointments. The length, frequency and number of sessions will depend on the type of therapy that we do and the goals that we establish together. Appointments normally last 50 minutes. I try to be flexible in scheduling appointments if your commitments do not permit a regular meeting time. Once an appointment time is scheduled, the time slot will be held for you unless I receive notice at least one week in advance. For example, if our session is on Wednesday, you must notify me of your unavailability by the previous Wednesday. If you inform me less than one week in advance, you will be charged your usual fee for a missed, broken or canceled appointment. The only exceptions are cases of emergency (e.g. hospitalization, serious illness, sudden bereavement).

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FEES AND COSTS

Fees are to be paid in full at the time of each session. Should you request a modified fee, we will discuss the financial circumstances that require a reduction. Payment can be rendered by cash or electronically (via Paypal, Zelle) or credit card (Ivy Pay). For those who choose to use health insurance, my policy is that clients pay my full fee up front, and I will provide you with a monthly receipt that you can submit to your insurance carrier for reimbursement. Insurance carriers may have limited benefits that may directly affect clients' financial ability to stay in therapy. It is strongly suggested that you contact your insurance carrier in order to fully understand your coverage.

LETTERS AND DOCUMENTATION

The client may need letters and/or documentation to support the need for an emotional support animal, documentation for an academic withdrawal or deferment, academic disability accommodation, or housing arrangement at school. Additionally, the client may need documentation for paid family leave, FMLA, or disability. Other clients may need documentation for their attorneys.

I am more than willing to provide this, to the extent I am able. The client will need to complete a release of information and provide adequate time for me to complete the documentation in a timely manner. The client and I will need to co-collaborate on documentation to make sure all subject matters are covered adequately. I will ask you to review and approve the documentation prior to sending it to any third party that you have instructed me to.

REFERRALS

I only work within the scope of my practice and abilities. Some circumstances warrant referral to another professional. Should the need arise, I will discuss this with you and make every effort to arrange for a seamless transition. Our work together may indicate a need for medical attention, and since I am not a physician, I do not prescribe drugs nor offer any medical advice. I can, however, refer you to a medical doctor or psychiatrist, or work with your primary care physician, if this becomes necessary.

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COMPLAINTS AND CONCERNS

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of licensed marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

ELECTRONIC COMMUNICATION CONSENT

It is important that we both understand and accept the risks of electronic communication for communicating protected health information. I cannot guarantee the security and confidentiality of electronic communication and will not be liable for improper disclosure of confidential information that is not caused by intentional misconduct. Please be sure to notify me of any changes in your email address as well as any other contact information. Since electronic communication is part of our work together in therapy, the following are guidelines for email communication:

- Email or texting alone are never appropriate or sufficient for urgent or emergencies.
- Use another form of communication for sensitive information.
- Neither texting nor email are necessarily confidential. If relevant, an employer may have a legal right to read your email if he or she chooses. System administrators of most email systems have access to all of the email that goes through that system.
- If not already indicated by your email address, please include your name in the body of the email.
- Take precautions to protect the confidentiality of texts & email, such as using screen savers, safeguarding your computer password and replying or sending email using a secure email server.
- If you email me and don't receive a response within a reasonable time period, please follow up by another means.
- Email communication is considered to be part of the therapeutic process and therefore part of the clinical records. As such, the fee for time spent on email is in line with the therapist's regular rate per session. In other words, I do not charge for email, phone calls, and texting.

Please be aware that I do not engage with clients in any way on social media sites in order to best protect your confidentiality and to ensure the ethical boundaries of the therapeutic relationship. This means I do not accept requests for contacts, friends or fans (on sites like Facebook, LinkedIn, etc..)
from current or former clients. I encourage you to ask questions and to voice freely any dissatisfactions or needs with respect to the sessions or progress in therapy. Continued review of our work together and of progress toward achievement of goals for therapy will facilitate awareness of when it is time to conclude therapy or make changes in this therapy contract.

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The purpose of this form is to clarify our agreement regarding treatment, policies, fees, and time. Please read it carefully and, if you agree with its contents, please sign and date it below. I look forward to reviewing and discussing this together.

Fee of: $ _____ For a 50 minute session

CLIENT SIGNATURE: _____ DATE:

THERAPIST SIGNATURE: _____ DATE:

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ELECTRONIC PAYMENT AUTHORIZATION FORM

Name: _____ Today's Date:

Electronic Payment Method: Ivy Pay

Terms and Conditions:
I authorize Jessica Lief to charge or receive payment for professional services in her legal capacity.

- I understand that this information will be held in a password-protected computer and/or a locked and secure file cabinet within the office at all times. Jessica Lief will be the only person who has access to this information.
- I am aware that electronic payment methods may not be entirely confidential. I acknowledge that Jessica Lief will use the strictest privacy settings available for all electronic payment methods in order to protect confidentiality.
- I authorize Jessica Lief to use this information to recover any Outstanding charges that may be due on my account, including late fees, missed appointments, and past due balances.
- I understand that this information will be destroyed when my professional relationship with Jessica Lief has been terminated.
- While I may use the above platform to pay for regular payment, the information included on this form is intended solely to recover any fees that are rightfully due to Jessica Lief. I agree not to "contest" or charge back any fees.

CLIENT SIGNATURE: _____ DATE:

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TELETHERAPY CONSENT FORM

Definition of Services:

I, _____, hereby consent to engage in teletherapy with Jessica Lief. Teletherapy is a form of psychological service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand teletherapy involves the communication of my medical/mental health information, both orally and/or visually.

Teletherapy has the same purpose or intention as psychotherapy sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to face treatment sessions.

I understand that I have the following rights with respect to teletherapy:

Client's Rights, Risks, and Responsibilities:

1. I, the client, need to be a resident of California, New York, and/or Massachusetts. (This is a legal requirement for psychotherapists practicing in this state under a CA, NY, MA license.)

2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

3. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which I have discussed with Jessica and agreed to in our initial session(s).

4. I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my psychotherapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

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5. There is a risk that services could be disrupted or distorted by unforeseen technical problems.

6. In addition, I understand that teletherapy-based services and care may not be as complete as face-to-face services.

7. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse.

8. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support. Clients who are actively at risk of harm to self or others are not suitable for teletherapy services. If this is the case or becomes the case in future, my therapist will recommend more appropriate services.

9. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the psychotherapist to do the same on their end.

10. I understand that dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

11. I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Jessica Lief providing health care services to me via telemedicine.

12. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine.

13. I hereby authorize Jessica Lief to use any HIPAA-compliant platform as a means for providing psychotherapy remotely.

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14. I further attest that since I have chosen this form of communication, I have been advised that it may not be covered by my insurance company and that I am responsible for any fees incurred during psychotherapy which incorporates telecommunication.

15. I understand that I may revoke this authorization at any time by giving written notice, except to the extent Jessica Lief has already taken action in reliance on it. I may specify the date, event, or condition on which this consent expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date it was initiated.

I have read, understand and agree to the information provided above regarding telehealth:

CLIENT SIGNATURE: DATE:

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CONSENT FOR EXCHANGE OF CONFIDENTIAL INFORMATION

(RELEASE OF INFORMATION)

I, _____ , hereby authorize Jessica Lief, to exchange information in a confidential and professional manner, with the organization(s)or person(s) listed below:

Name: _____

Address: _____

Relationship: _____

Phone: _____

This disclosure is to be made for the purpose(s) of:

- Conducting therapy sessions
- Insurance payment or reimbursement
- Furnishing information to my health care provider
- Coordination of case management
- Emergencies as needed

Other: _____

This consent will remain valid until the date specified below, although it is subject to revocation in writing at any time, except for information that may have been released prior to revocation.

Unless revoked by me sooner, this consent will expire on:

CLIENT SIGNATURE: _____ DATE: _____

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EMERGENCY CONTACT FORM

I, _____ , hereby allow Jessica Lief to contact my emergency contact if she assesses that this is necessary due to an emergent situation with myself or my clinical care.

My emergency contact that I have identified is:

Name: _____

Relationship: _____

Address: _____

Phone: _____

Email: _____

This consent for my emergency contact to be contacted in case of emergency will be valid for a year from today, _____

CLIENT SIGNATURE: _____ DATE: _____

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CLIENT MAILING AND HOME ADDRESS

Your safety is the most important part of our work together. In case of emergency, it is imperative that I have a way of reaching you. In addition, payment and insurance forms require your address and may also be mailed to you. Please note that I will never send materials to your place of residence without first consulting you.

Client's mailing address: _____

Client's home address (if different from mailing address): _____

PROFESSIONAL LICENSING INFORMATION AND QUALIFICATIONS

I hold a Masters degree in advanced clinical social work practice from New York University. I also hold a Masters degree in health law from UC Law San Francisco (formerly UC Hastings College of the Law). Additionally, I hold a Doctorate of Social Work from Simmons University in Massachusetts. I have been practicing as a psychotherapist since 2014 and have been licensed in the state of California since 2018. Additionally, I am licensed in Massachusetts and New York. Please refer to the licensing information below. I conduct therapy via telehealth or in my office in San Francisco. My clientele consists of individuals and families. I work on an outpatient basis only.

December 2018-Present
Licensed Clinical Social Work
California Board of Behavioral Sciences

LCSW# 87286
December 2023-Present
Licensed Independent Clinical Social Worker
Office of Health and Human Services • Massachusetts

LICSW #126368 (by reciprocity)
June 2026-Present
Licensed Clinical Social Work
The University of the State of New York Education Department
LCSW# 103309