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**IMPORTANT INFORMATION AND CLIENT CONSENT:** Please read and sign at the end stating you have fully read and understand the information below.

**CLIENT/PSYCHOLOGIST RELATIONSHIP:** You and Dr. Beth Cook have a professional relationship existing for therapeutic treatment. This relationship functions most effectively when it remains professional and involves only the therapeutic aspect.

**AVAILABLE SERVICES:** Dr. Beth Cook offers a wide array of counseling services, including individual, family, couples, and group services. Effective psychotherapy is founded on mutual understanding and good rapport between client and Psychologist. I will communicate the policies and procedures used in our practice, and I will be pleased to discuss any questions or concerns you may have.

**RISKS AND BENEFITS:** Psychotherapy may be beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving.

**Therapy:** I provide short-term therapy designed to address many of the issues clients are dealing with. Your first visit will be an assessment session in which you and I will determine your concerns, and if both of us agree that I can meet your therapeutic needs, we will develop a plan of treatment.

The goal of psychotherapy is to provide the most effective therapeutic experience available to you. If at any time you feel that we are not a good therapeutic fit, please discuss this matter with me as soon as possible. If we decide that other services would be more appropriate, I will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Psychotherapy services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

**APPOINTMENTS:** Appointments are typically scheduled on a weekly basis and are approximately 60 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate.. If you must cancel or reschedule your appointment, we ask that you call at least 24 hours in advance, whenever possible. This will free your appointment time for another client. Without 24 hours notice, you will be charged the full session fee.

**FEE SCHEDULE:**

Diagnostic & Evaluation Session (1 <sup>st</sup> visit)	\$300
All other charges are based on an hourly fee of	\$285
Regular Office Visits (60 minutes) (Individuals, Couples Therapy)	\$285
Disability forms (one time fee)	\$225
Written Reports	\$225

**PAYMENT/INSURANCE FILING:** I request that payment be made at the end of each session. If you are using insurance benefits, I will electronically file insurance claims for you and you will be directly reimbursed according to the plan benefits. You may use credit card, venmo, zelle or paypal for your session fee.

**EMERGENCIES:** You may encounter a personal emergency which will require prompt attention. In this event, please contact me regarding the nature and urgency of the circumstances. I will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, I will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours, you may try to reach me but if you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help.

**CONFIDENTIALITY:** Dr. Beth Cook follows all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Psychologist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Psychologist has a duty to disclose, or where, in the Psychologist's judgment, it is necessary to warn or disclose; fee disputes between the Psychologist and the client; a negligence suit brought by the client against the Psychologist; or the filing of a complaint with the licensing or certifying board.

If you have any questions regarding confidentiality, please speak with me about your concerns.. By signing this Information and Consent Form, you are giving consent to Dr. Beth Cook to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless Dr. Beth Cook from any departure from your right of confidentiality that may result.

**DUTY TO WARN/DUTY TO PROTECT:** If Dr. Beth Cook believes that I am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to Dr. Beth Cook to contact the person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to Dr. Cook to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name

Telephone Number

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**INCAPACITY OR DEATH:** I understand that, in the event of the death or incapacitation of Dr. Beth Cook, it will be necessary to assign my case to another Psychologist and for that Psychologist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by Dr. Beth Cook, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

**CONSENT TO TREATMENT:** By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or the Conserved Individual if said individual is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a Conserved Individual, if a court order has been entered

with respect to the conservatorship of said Conserved Individual, or impacting your rights with respect to consent to the Conserved Individual's mental health care and treatment, Dr. Beth Cook will not render services to the Conserved Individual until the Psychologist has received and reviewed a copy of the most recent applicable court order.

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Signature – Client/Guardian Date

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Signature – Spouse/Partner/Guardian Date

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Psychologist Date

**I hereby authorize the release of necessary medical information for insurance reimbursement purposes.**

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Client/Guardian Date

**I authorize the payment of medical benefits to the provider of services.**

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Client/Guardian Date