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INFORMED CONSENT AGREEMENT FOR EAP CLIENTS

WELCOME

Welcome to my practice! I appreciate your trust and the opportunity to work with you.

This document is designed to answer some frequently asked questions about my practice and our relationship, so please read all of it. As you read, please feel free to mark any information that is not clear to you or write in any questions that come to your mind so that we can discuss them. I ask that you read this document in order to indicate your understanding of my office's procedures and your willingness to abide by these policies.

TREATMENT

I am a Licensed Psychologist who practices creative arts therapies, mindfulness approaches, and sensorimotor psychotherapy in addition to traditional verbal therapy. I studied dance/movement therapy approaches at the University of California, Los Angeles, hold Master's and Doctorate degrees from the California School of Professional Psychology in Los Angeles, and am currently receiving training and consultation in Sensorimotor Psychotherapy. I work with children and adults in individual, couples, and family therapy. I offer traditional verbal therapy, at times combined with the use of mindfulness-based approaches and movement and other creative expressions, to facilitate clients' increased awareness of personal thoughts, feelings, beliefs, behaviors, and interactions. Since you have been referred to me by your Employee Assistance Program, you and I will most likely meet for a brief series of sessions. Our work will likely consist of traditional verbal therapy. However, some EAP clients find mindfulness-based practices helpful in reducing stress and facilitating mental and physical well-being. If this is true for you and if you would like, some of our work together may involve practicing mindfulness-based techniques.

MEETINGS

I usually schedule a weekly fifty-minute session with clients in individual, couples, or family sessions. But some EAP clients find it more helpful to meet either more or less than once a week, depending upon the number of sessions they have been allocated and the particular situation that led them to seek EAP services. We will schedule our meetings cooperatively for our mutual convenience. I will inform you in advance about the times I will not be in the office. Feel free to ask about my schedule in making your own plans.

An appointment is a commitment to our work and a contract between us. We each agree to be here and on time. If you are late, we will be unable to meet for the full time scheduled. Your session time is reserved for you. A canceled appointment is an interruption in our work, which will delay completing it. I ask that you inform me at least 24 hours in advance (by phone or e-mail) if you can't keep your appointment. Occasionally, there may be emergencies that will prevent us from meeting as arranged. If I have an emergency, I will do my best to inform you promptly so that we can reschedule our time together. If you have an emergency, I expect you to do the same.

CONTACTING ME

Out of consideration for the person I am working with, I do not take phone calls when I am in session. But as soon as I can, I will pick up your message and return your call. If you call me when I cannot answer the phone, you will hear my voicemail message. Please leave a message that includes your full name, area code, phone number, best times to reach you, and indicate whether or not your call is an emergency. I check my messages regularly and will return your call as soon as possible, unless I am out of town. If your call is an emergency and I do not call back within one hour after your message, I encourage you to call the crisis line (800- 273-TALK) or to go the nearest emergency room and ask for the psychiatrist or psychiatric resident, or call 911. Please do not use e-mail for emergencies.

If I have not returned your call within 24 hours on a weekday that I have not informed you that I will be out of town, please call again, as there may have been a voicemail failure.

I may use e-mail to remind you of an upcoming appointment or to reschedule one. Sometime I use e-mail to send you resources or articles relevant to our continuous work. As you may know, communication over the Internet may not be completely confidential. Please let me know if you prefer that I do not contact you by electronic means.

CONFIDENTIALITY

I regard the information you share with me with the greatest respect so I want us to be as clear as possible about how it will be handled. The privacy and confidentiality of our conversations are privileged, legally protected by federal and state law and by my profession's ethical principles, in all but a few rare instances. These instances are explained in your *Statement of Understanding*, which you will read and sign as we begin our work together.

Occasionally, I consult on cases with colleagues or specialists (who are also ethically required to maintain your confidentiality), so some aspects of our work may be shared. Your personal identifying information will never be revealed in such circumstances.

Otherwise, I do not and will not tell anyone anything about your treatment, diagnosis, history, or even the fact that you see me, without your full knowledge and a signed *Release of Information* document.

ADDITIONAL ITEMS

Although I share the office suite with other therapists, each of us operates independently and is solely responsible for the quality of care provided.

It is possible that, if you are married or have children, you may become involved in a divorce or custody dispute. If this occurs, I will not be available to provide expert testimony in court, and you should separately engage a court-appointed child custody evaluator. This is for two reasons: (1) my evaluations will be seen as biased in your favor because we have a therapeutic alliance, and (2) the testimony might negatively affect our therapeutic relationship.

Psychotherapy implies a trusting and open relationship as well as one of safety and confidentiality. For these reasons, psychotherapists do not have business or other relationships with their clients besides the therapeutic one, except under certain circumstances that are unavoidable. If we happen to unexpectedly meet outside of session, I will leave it up to you to decide whether you and I will interact. Should the need arise, this is an issue we can discuss during our sessions to determine the best way of handling it.

In my professional practice as a therapist, I do not discriminate in accepting and working with clients on any of these bases: age, gender, marital status, race, color, religious beliefs or creed, belief, ancestry, national or ethnic origin, ethnicity, location of residence, physical or mental disability or handicap, veteran status, sexual orientation, or health status. This statement is both a personal commitment and is made in accordance with federal, state and local laws and regulations. If you believe that I have acted otherwise, I am open to discuss the matter with you at any time.

I have carefully read the above *Informed Consent Agreement* (which totals 2 of 3 pages, with information requested filled out on the following page 3). I understand and agree with it:

_____ Client name (please print)	_____ Signature	_____ Date
_____ or Legally Authorized Representative, if applicable (please print)	_____ Signature	_____ Date
_____ Therapist name (print)	_____ Signature	_____ Date

To assist in our work together, please provide the following information:

CONTACT INFORMATION

Person living in the local area designated by you as an emergency contact:

First Name	Last Name	Relationship to you	
Address	City	State	Zip
Cell Phone	Home Phone	Work Phone	

Living relative designated by you as an emergency contact:

First Name	Last Name	Relationship to you	
Address	City	State	Zip
Cell Phone	Home Phone	Work Phone	

MEDICAL & MENTAL HEALTH INFORMATION

Your Primary Physician:

Physician's Name	Office Address	City	State	Zip	Office Phone
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Please list any illnesses, injuries, or recent surgeries or hospitalizations and their dates: _____

Medications you are currently taking: _____

Your Psychiatrist (if you have one):

Psychiatrist's Name	Office Address	City	State	Zip	Office Phone
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Please list any psychiatric medications you are currently taking: _____

Please list any psychiatric hospitalizations and their dates: _____

Please describe anything else that you would like me to know: _____
