**Rosita Cortizo, PsyD, MFT, MA**

**(619) 920-1638**

**CONSUMER INFORMATION SHEET**

**Credentials:** I am a California State licensed Clinical Psychologist and a licensed Marriage, Family and Child Therapist with a main focus on relational issues. I have a Clinical Psychology Doctorate (professional psychology), a Master of Arts in Marital and Family Therapy, and a Master’s Degree in Psychology/Chemical Dependence. I am qualified to provide individual, couple, children, family and group therapy. I specialize in grief counseling, child abuse, chemical dependence, trauma, ethnic issues, parents of handicapped children, and patients with physical and psychiatric illness.

**Therapy time:** Appointments usually last 45-50 minutes.

**Confidentiality policies:** What is discussed in therapy is confidential between the therapist and client(s) UNLESS the client(s) give written permission to release information to a specific person(s) or agency. Without the release, NO INFORMATION is available to ANYONE without an appropriate court order. There are three exceptions: **1)** if the therapist has reason to believe you are in danger of hurting yourself, **2)** if the therapist has reasons to believe you are in danger of hurting someone else, including a child, and **3)** if the therapist has reasonable suspicion that a child or an elder are being abused. In such cases, “Confidentiality” will be waived, and a Child or Adult Protective Services referral will be made.

**Fees:** Fees are due at the beginning of each therapy session, or the bills will be sent to the Victim Compensation Program, T.E.R.M., or insurance company approved by the therapist. Accepted payment methods are cash or check. Any and all client services are to be paid at the time of services. Non-payment will constitute in a discontinuation of services. There will be a $25.00 service fee for each returned check. Payment of the service fee and amount of the returned check must be paid before continuing services.

Insurance companies may be accepted with few exceptions. If you have insurance that requires co-pay, **you are responsible for paying that amount** **at the beginning of each session**. You are responsible for any unpaid balances by the insurance company. Charges for unpaid balances by the insurance are as follows: $150.00 for an initial assessment and $150.00 for each follow up session. The charge for letters is commensurate with the time needed for preparation. All letter requests must be at least 10 working days in advance.

You also need to be aware that I may employ administrative staff. I may need to share protected information with these individuals for administrative purposes, such as scheduling, billing, and quality assurance. Any staff I use will receive training about protecting your privacy. I may also utilize a clearinghouse which submits electronic claims to insurance companies. As required by HIPAA, I will have a formal business agreement in which the clearinghouse promises to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.

**Cancellation:** A notice of cancellation is required 24 hours in ADVANCE. You may call the 24-hour telephone number provided above. Since appointment times are reserved exclusively for you, you will be charged $90.00 for the session if the 24-hour notice of cancellation is not met. Payment for missed sessions must be made prior to the beginning of your next appointment. More than two cancellations or no shows will be reason to terminate treatment. **INITIALS:\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Warning**: It is your responsibility to ask for a card with the date and time of your next appointment. If your card is lost, the appointment will be the one specified in the Doctor’s agenda.

I have read the above, understand the content, and agree to the conditions stated.

YOUR SIGNATURE BELOW CONFIRMS OUR MUTUAL AGREEMENT TO TERMS OF SERVICE.

**Print Name**

**Signature Date**