

**Nahal Delpassand, PsyD, PLLC**

Licensed Psychologist  
1600 W. 38<sup>th</sup> St. Suite 428  
Austin, TX 78731  
512-454-3685

**CONSENT FOR PSYCHOTHERAPY/COUNSELING**

• The **Therapeutic Process** and the **Therapeutic Relationships** are complex things. Characteristics of both therapist and client(s) greatly affect the course of treatment and of the relationship. I personally view this therapeutic alliance as a partnership wherein we work together in discovering what methods might best lead you to better mental and physical health, improvements in your relationships, as well as to an overall better sense of well-being. You, the client, hold great responsibility in working toward goals set regarding treatment. Therapy is not magic – it can be hard work, and generally speaking, I believe you can get out of it what you put into it.

• **Benefits and Risks of Therapy** – Therapy can assist you in working toward developing and acquiring insight and skills which can lead to a more desirable and/or functional way of life. This implies change. Although change often results in desired benefits, change can also yield result that may surprise you. Some examples may be feelings of sadness, loneliness, anxiety, frustration, anger, or guilt. It is also possible to experience resistance within current relationships as you move toward change. While predicting such occurrences is impossible, it is important to realize there is a potential for these feelings or issues to surface.

• **Crisis / Emergency Services** – Please note, Dr. Delpassand does NOT offer crisis / emergency services. Dr. Delpassand also does not have an after hours "on call" service. If you experience a crisis or emergency between sessions, please call 911 and go to your nearest hospital emergency room.

• **Length of Therapy** – Therapy can be short or long-term. Time frame can be difficult to determine and depends on the nature and depth of the issues presented as well as on how the course of treatment is progressing. My personal goal is to foster and empower the development of skills and knowledge that will be useful and beneficial to you in your everyday life. I encourage discussion at any and all times when you, the client, would like to discuss goals specific to length of treatment. This type of discussion may include the issue of **termination of therapy**, and yes, termination is a goal. Termination of therapy tends to be a joint decision and may be brought to the discussion table at any point by either the therapist or by the client.

• Know that you, the client, have the right of **Access to your Files**. Third parties are not entitled to this information without your consent except in situations specific to confidentiality issues (which are explained in the “confidentiality” section).

• Therapy takes place in many forms and there are **Alternatives to Traditional Therapies**. If you are not satisfied with your course of treatment, we can discuss alternatives available to you and if necessary, I will provide you with an appropriate referral for such services.

**FEES AND PAYMENT**

• My standard fees are \$300 for the intake session (90 minutes) and \$200.00 per 50-minute session thereafter.

• You are responsible for making payments on the day of your session by cash, check or Venmo. Checks are to be made payable to Dr. Nahal Delpassand. Venmo is not HIPAA compliant; there is a risk of confidentiality breach if settings are not set to private.

• **If payment is not made at time of service, a fee of \$25.00 will be added to the total outstanding balance for each late payment.**

**APPOINTMENTS AND CANCELLATIONS**

• Where possible, I offer clients a regular weekly time-slot. This slot is reserved for you and I will expect you at that time each week unless you notify me otherwise. Regular attendance (maintaining an average of 4 out of 5 sessions) is necessary if you wish to retain your reserved time. Two consecutive late cancellations or no-shows will result in your time-slot being revoked.

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- Non-emergency cancellations must be received at least 24 hours in advance of your appointment time (note that cancellations for Monday must be received before noon on the preceding Friday). Late cancellations or failure to show for a session will incur the full \$200.00/\$300.00 fee for all clients.

## **TERMINATION OF THERAPY**

In the best possible scenario, therapy is terminated when both therapist and client believe the work is complete and meets for a closure session. Sometimes, however, therapy terminates for a variety of other reasons, including a lack of fit between therapist and client, a lack of fit with the therapist's treatment modalities, or simply that it is not the right time in the client's life. In these cases, I would greatly appreciate the opportunity to discuss your experience with you and send you on your way with alternative referrals. If, for whatever reason you are not comfortable doing this, please send an email or leave a voicemail letting me know that you wish to take a break from therapy so that I am not holding your slot for you.

## **CONTACTING ME**

I can be contacted directly on **832-818-4989** or by email at **Nahaldelpassand@hushmail.com** When I am with clients or away from the office, my phone typically rolls straight to voicemail, which I check regularly. Please leave a message and I will call you back as soon as I can. Due to the fact that the privacy of electronic information cannot be guaranteed, please restrict the content of all emails and text messages to administrative issues, such as scheduling and billing.

**Couples Therapy:** When providing couples therapy, I consider myself responsible to three "clients": Partner A, Partner B and the relationship. In order to protect the integrity of the therapy, any information disclosed individually to me that significantly impacts the current status of the relationship may ultimately need to be disclosed to the partner if therapy on the relationship is to continue. Please do not send emails or leave voicemails that you would not wish your partner to be privy to.

**Interactions Outside of Therapy:** Occasionally clients and therapists run into each other outside of therapy, for example: in grocery stores, restaurants, at educational institutions or conferences. My policy in these situations is to protect client confidentiality. I will never acknowledge a current or former client unless the client acknowledges me first, nor will I introduce a client to anyone that I happen to be with. In situations where we may be introduced to each other by a third party, I will behave as though it is the first time we've met. If, during a therapy session, you would like to discuss the handling of any potential or actual public interactions, please let me know.

**Social Networking:** In order to maintain client confidentiality, I do not connect with former or current clients on social networking sites, including Facebook, Instagram, Snapchat or LinkedIn. **CONFIDENTIALITY** – One of the most important aspects of the therapeutic relationship is the element of trust. Trust is fostered in many ways throughout the course of treatment, and the promise of confidentiality is primary. It is important to understand that

**CONFIDENTIALITY IS NOT ABSOLUTE.** There are instances where I have either a legal or ethical obligation to breach confidentiality and they are outlined below:

- **Child Abuse:** If I have cause to believe that a child has been, is currently being, or may be abused, neglected, or sexually assaulted, I am required by law to notify appropriate law enforcement authorities within 48 hours. Please know this policy extends to past child abuse as well.
- **Elder Abuse and Abuse of persons with disabilities:** If I have cause to believe that an elderly or person with a disability is in conditions of abuse, exploitation, or neglect, I am immediately required to report this to the Department of Protective and Regulatory Services.

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- **Harm of Self or Others:** If I determine there is probability of imminent physical injury inflicted upon yourself or by you onto others, or if there is probability of immediate mental or emotional injury to you, I may disclose information relevant to such circumstances to appropriate medical or law enforcement personnel.
- **Judicial or Administrative Proceedings:** If you are involved with a court proceeding, information pertaining to your treatment and the corresponding records can only be turned over with your written consent or that of your legally appointed representative to do so –OR–if mandated of my by court order. Dr. Delpassand does not get involved, under any circumstances, in custody proceedings nor will she testify on behalf of either client or clients’ parent/guardian.
- **Abuse by a mental health professional:** Therapists are required by law to report incidents of sexual misconduct on the part of other therapists. In this situation, I am not permitted to disclose the identity of a client who wishes to remain anonymous.
- **Release of Information:** You may request, in writing, that information be shared with or released to persons, agencies, or organizations you specify.
- **Colleagues/Supervisors/Mentors:** It is customary for mental health professionals to consult with our peers. I do consult with colleagues from time to time, in order to assure the highest quality of service. No identifying information about you will be shared during these consultations without your permission.
- **Consultation:** I frequently consult with colleague Dr. Melinda Longtain regarding complex cases. If you have any questions or concerns about this please discuss with me during your initial visit.

**Your signature below** indicates that you have read, understood, and agree to abide by these policies. You will be provided with a copy of this document. Your signature further acknowledges that you have received and reviewed a copy of this office’s **Notice of Policies and Practices to Protect the Privacy of my Health Information**, which explains how your health information will be used and disclosed.

Additional agreements, if any: \_\_\_\_\_

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\_\_\_\_\_  
*Signature of Client*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name of Client*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Parent/Guardian*

\_\_\_\_\_  
*Date*