**SETH PROSTERMAN, Ph.D.**

**Certified Sex Therapist &**

**Licensed Marriage & Family Therapist**

2 9 1 8 W e b s t e r S t r e e t

S a n F r a n c i s c o, CA 94123

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**PROFESSIONAL DISCLOSURE STATEMENT**

1. **Treatment Expectations:**

In general, I attempt to carry out treatment that is shorter term and present-focused, with the intention of getting you to your goals as soon as possible. There are times, however, when longer-term work may be necessary, especially when childhood events or other experiences from the past are affecting your ability to make gains in the present. The length of therapy will depend on your needs, goals and motivation. Initial sessions are designed to build a foundation for our work together. This often includes a problem history, which will allow me to gain a fuller understanding of the problem from your perspective, followed by a more in-depth family, relationship or sex history. By the third session, if not earlier, we will delineate the goals and expectations that you have for therapy. In addition to our work in the office, you may be asked to carry out specific homework assignments that will support the therapeutic process. Counseling sessions, at-home assignments and other interventions are carefully formulated with regard to your treatment goals, and as such, they may elicit anxiety, discomfort or painful emotions in the individual, couple or family system. Periodically we will review your progress to determine how close you are from completion of your goals. If appropriate or desired, referrals to other professionals (mental-health and/or medical) or adjunctive support groups may be made.

Therapy is most effective and efficient when provided on a weekly basis. Coming less often may dilute the therapy process and stretch out the time it takes you to reach your goals.

1. **Confidentiality:**

Counseling sessions will be kept strictly confidential except for the limits imposed by California law regarding protection of people. These exceptions include reporting serious intentions to hurt oneself (suicide), to hurt another person, or any suspected incidence of physical, sexual or emotional abuse of a child or an elderly person. In all other situations, you (each member of the couple or adults in the family involved) will be asked to sign a "Release of Confidential Information Form" prior to the release of any confidential information. Confidentiality issues regarding parents and children will be discussed further, if applicable.

1. **Therapy Agreement:**  (please read and sign below)
2. **Fees and Session Length:** I understand that the fee for this counseling service is for a 50 minute, in-person or online therapy session, payable prior to or during each session. The remainder of the hour is for administrative matters (payment, scheduling, etc.). Sessions that are scheduled to go beyond the initial hour, as well as, telephone consultations will be billed in 30 minute increments. The client agrees to pay all fees incurred by returned checks.

1. **Insurance Reimbursement:** I am responsible for full payment per session even if I plan to bill insurance for reimbursement. There is no guarantee that insurers will reimburse me for services rendered by a licensed MFT. If I intend to use insurance, I will inform Dr. Prosterman at the onset of therapy. An insurance or HAS invoice will be provided upon request.
2. **Cancellation Policy:** I understand that canceled appointments will be billed as though the appointment had been kept **unless cancellation is made a minimum of 24 hours prior.**
3. **Lateness Policy:** If I do not appear or let Dr. Prosterman know that I will be late within the first 20 minutes of the scheduled session time, it may be assumed that I will not appear for the session. I understand that if an appointment was scheduled for me, I am responsible for full payment of that session. Please try to inform Dr. Seth if you realize that you are going to be late. Call or text Dr. Seth at (415) 948-9590.
4. **Termination of Therapy:** Termination of therapy will usually occur in a face-to-face session. Termination usually comes as a mutually discussed decision once I have achieved my goals. If at that point, I wish to work on additional goals, Dr. Prosterman and I will consider additional therapy.

**YOUR RIGHTS**

I am encouraged to ask questions about any procedures that are used during our counseling work together. At any time, I may end therapy without any moral, legal or financial obligations other than those already incurred. Dr. Prosterman will be happy to discuss other treatment methodologies or provide me with referrals to other qualified professionals upon request.

**My signature(s) below indicates that I have been informed of the limits of confidentiality and have read and agreed with the above:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_