Dr. Victoria Curea – Marriage and Family Therapy, Inc.
11845 West Olympic Blvd., Suite 1255W, Los Angeles, CA 90064
(310) 275-8050
MFC41124

TREATMENT INFORMATION and CLIENT INFORMED CONSENT

To the patient,

You agree to enter into treatment with me with the assurance I will perform to the best of my ability and within my scope of practice. The outcome of your treatment depends largely on a collaborative rapport between us and your willingness to engage in the process. You have the right to end your treatment at any time, for whatever reason, without any moral, legal or financial obligation except for fees already incurred. You have the right to question any aspect of your treatment with me. You also have the right to expect I will maintain professional and ethical boundaries by not entering into other personal, financial or professional relationships with you, all of which would greatly compromise our work together. Usually, patients participate in psychodynamic treatment for a minimum of 6-12 months but this time can vary greatly depending on your treatment needs and goals. Any discussion of your fee should take into consideration the potential for treatment to extend beyond 12 months.

I am licensed in the state of California and am only able to provide counseling services if you reside in this state or can provide a California address where you will be residing during treatment and can be contacted in the event of an emergency.

If I determine you would benefit from adjunct or other forms of treatment, I may make referrals to other clinicians or agencies. Depending on the circumstance, this may bring about a pause or termination of your treatment with me. The need to refer for additional resources will be discussed with you and you will have an opportunity to respond to my recommendations. In the event I am unable to treat you for any reason, you will be provided with appropriate referrals to other clinicians or agencies. If during the course of treatment you become unable to pay your fee and we are unable to negotiate a new rate which would allow you to remain in treatment with me, I will provide you with appropriate referrals to maintain continuity of care. Under most circumstances, maintaining your mental health care remains solely your responsibility unless you require a higher level of medical care at which time I may involve your emergency contact and/or medical personnel to ensure your safety.

You will be given a copy of the **HIPAA** (Health Insurance Portability and Accountability Act) and asked to review it. The HIPAA outlines in detail the times in which your private health information (PHI) may be shared with or without your consent. Signing this document also gives me permission to communicate with you and medical entities electronically (fax, email, etc.) It is important you become familiar with this document so you will understand the limits of confidentiality and the efforts I will make to manage your PHI (protected health information.)

Most sincerely,

Victoria Curea, Psy.D, LMFT

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11845 West Olympic Blvd., Suite 1255W, Los Angeles, CA 90064
(310) 275-8050 phone (323) 709-0490 fax
CA Lic. MFC41124

NEW PATIENT(S)

In order to receive counseling services, you must be able to provide an address in **California** which is either your primary residence or a residence where you will reside and receive mail during your treatment.

NAME:		
PRIMARY RESIDENCE ADDRESS:		
CITY:	STATE:	ZIP:
MAILING ADDRESS (if different from above):		
CITY:	STATE: **California**	ZIP:
HOME PHONE:	MOBILE PHONE:	
EMAIL ADDRESS:		
EMERGENCY CONTACT:	THEIR PHONE:	
REFERRED BY:		

If presenting for Couples or Family Therapy, please have all additional individuals seeking treatment provide their contact info below. If additional space is needed, please request or print additional copies of this page.

NAME:		
STREET ADDRESS:		
CITY:	STATE:	ZIP:
MAILING ADDRESS (if different from above):		
CITY:	STATE: **California**	ZIP:
HOME PHONE:	MOBILE PHONE:	
EMAIL ADDRESS:		
EMERGENCY CONTACT:	THEIR PHONE:	
REFERRED BY:		

Victoria Curea, PSY.D, LMFT

A checklist should be completed by each person seeking treatment.

Name	Age	Birth Date	Today's Date
Reason(s) for seeking therapy:			

Symptom & Severity	None	Mild	Moderate	Severe	Duration
Depressed Mood, Hopelessness					
Suicidal Thoughts					
Anxiety, Frequent Worry or Tension					
Anger, Hostility, or Feelings of Rage					
Violent Acts					
Impulsivity or reactivity					
Compulsive Behaviors					
Interpersonal problems in relationships					
Problems with Sexual Function					
Concerns re: Sexual Orientation					
Concerns re: Gender Identification					
Weight Fluctuations					
Eating Problems					
Difficulty maintaining proper nutrition					
Substance Use					
Maintaining substance use recovery					
Sleep Problems (too much/too little)					
Difficulty communicating with others					
Financial Problems					
Employment Difficulties					

- When was your last physical examination? _____
- Please list any chronic medical conditions: _____
- Are you currently in the care of a psychiatrist? If so, please provide their name and contact info:

  _____
- Are you currently taking any prescribed medications? If yes, please specify: _____

  _____
- Have you been in mental health treatment before?_____
- Has anyone in your immediate family ever been diagnosed with a mental illness? Please specify:

  _____
- Have you or anyone in your immediate family ever attempted suicide? _____

  _____
- Have you or anyone in your immediate family ever sought treatment for substance abuse? _____

  _____

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FEE AGREEMENT

- I understand my fee has been set at $275 (individuals) or $350 (couples) per 50-minute session. Other: _____
- I have read the cancellation policy, understand how and when my treatment fee will be charged and what I can do to ensure weekly meetings with my therapist.
- I understand fees for treatment are payable at time of service.
- Fees can be paid using Zelle; Visa, Mastercard, and American Express credit cards; personal checks or cash.
- **By initialing here _____, I am authorizing Victoria Curea, PSY.D, LMFT to automatically charge my credit card on file for the fees associated with my treatment.** I understand my credit card will be charged when I have received counseling services or when I have cancelled an appointment within the 24 hour window.
- INSURANCE: Should I wish to use my insurance, I understand I must request from Victoria Curea, Psy.D, LMFT a document which contains dates of service, location of service, amount paid for service and a diagnosis code. I understand that only sessions I have paid for AND attended will be included on my insurance statement.
- If I have insufficient funds to cover my personal check at the time of its deposit, I will be required to pay the full amount of the check plus any bank fees incurred by Victoria Curea, Psy.D, LMFT (normally between $20.00-$35.00 per check.)
- I understand my fee may be reviewed periodically, especially if my financial situation should change during the course of treatment. Any changes to my fee will take into account what I can afford. Should I become unable to pay the agreed upon fee for service, Victoria Curea, Psy.D, LMFT will provide me with appropriate psychotherapy referrals to ensure continuity of treatment.
- BALANCE ON ACCOUNT: If I leave treatment with an outstanding balance, I will need to make and maintain reasonable payments, discussed and agreed upon with my therapist, in order to bring the balance owed to zero.

CREDIT CARD# _____ Exp. Date: ____/____ Security Code: _____

NAME ON CARD: _____ Billing Zip Code: _____

By signing below, I agree to the above terms.

_____ _____
Client Name Client Name

_____ _____
Client's Signature Date Client's Signature Date

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INFORMED CONSENT FOR TREATMENT

This is a two (2) page document. Please make sure you read, initial and sign both pages.

INITIAL _____

CONFIDENTIALITY: I am legally prohibited from revealing to another person that you are in therapy with me. Unless you provide me with written permission, I cannot reveal what you have said to me in any way that identifies you. There are, however, some instances when your right to confidentiality must be set aside as required by law or professional guidelines. In all of the cases below, it is incumbent upon me to release only that information necessary to appropriately carry out my responsibilities.

- Instances of actual or suspected physical or sexual abuse; emotional cruelty, or neglect of a child or an elder or dependent adult, all must be reported to the appropriate protective services.
- If I have reason to believe that a client poses an unavoidable and imminent danger of violence to another person (or to another's property), I must warn whoever may be in danger and I must notify the appropriate authorities.
- If a court has ordered your treatment with me, or if I am served with a subpoena (i.e., in the context of a legal proceeding in which your psychological health is raised as an issue) I may be required by a judge to release information to the court or I may have to appear in court. Fees for this service will be discussed with you.
- If you reveal a serious intent to harm yourself, I am ethically and legally bound to do what I can to help keep you safe, which may involve notifying others who may be able to intervene.
- Federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances to provide FBI agents with requested items and prohibits the therapist from disclosing to the client that the FBI sought or obtained the items.

INITIAL _____

USE of CLINICAL MATERIAL in TEACHING: As part of my professional responsibilities as a professor and clinical educator, I may reference de-identified clinical material in my teaching, writing, or supervision of graduate students. Any such use will strictly protect your confidentiality. I will remove or alter all identifying details—including name, age, occupation, personal history, family structure, and any other characteristics that could reasonably lead to your identification. No information will ever be shared in a way that reveals your identity or allows others to recognize you. Your clinical material will only be used in a manner consistent with professional ethics, legal standards, and the protection of your privacy.

INITIAL _____

RECORDING of SESSIONS: To protect your confidentiality and maintain the integrity of the therapeutic process, recording of any kind is strictly prohibited. This includes audio recording, video recording, screen-recording, photographing, or capturing any portion of our sessions or written communications without my explicit prior written consent. I do not record sessions, and I do not authorize clients to record sessions. Any unauthorized recording constitutes a violation of this agreement and may result in termination of treatment.

INITIAL _____

USE of ARTIFICIAL INTELLIGENCE TOOLS: You may not upload, submit, transcribe, or otherwise disclose any portion of our sessions—including verbal content, written communication, case material, or personal information—to artificial intelligence platforms, machine-learning systems, chatbots, automated transcription services, or similar technologies (e.g., ChatGPT, Google Gemini, Otter.ai, Zoom AI Companion, or comparable tools). These systems may store, analyze, or reuse data in ways that compromise confidentiality and are not compliant with professional privacy standards. Any use of AI tools involving session material requires my explicit prior written consent.

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INFORMED CONSENT FOR TREATMENT

INITIAL _____ **TREATMENT FEES:** Once agreed upon, fees should be paid at the onset of each session. If using a credit card, your fee will be charged the day of your session in advance of your appointment so any problems that may occur with your payment can be discussed in person. Any fee change is negotiated in good faith. It is your responsibility to notify me if your financial situation changes. My fees may change over the course of treatment but always with consideration to your financial ability to stay in treatment. Typically, fees will be reviewed once yearly unless you and I have made other arrangements.

INITIAL _____ **SCHEDULING and CANCELLATIONS:** Our weekly appointment time is reserved for you. Appointment cancellations must be made 24 hours in advance of your appointment. If you cancel an appointment with less than 24 hours notice, you will be responsible for the fee for that session. Prolonged or repeated cancellations will be addressed clinically and may result in the forfeiture of your appointment time and referrals to other clinicians if we aren't able to resolve our scheduling difficulties.

INITIAL _____ **COMMUNICATION:** My email is DrVictoriaCurea@gmail.com. My phone number is (310) 275-8050. I am unable to respond to text messages. I will make every attempt to return calls and emails during business hours. Calls received after 7:00 pm will be returned the following day, Monday-Friday. If you and I have scheduled a phone session, you are responsible for any and all phone charges. Telephone consultations under 10 minutes will not be charged a fee however, consultations of greater length will be pro-rated based on your hourly fee. If you are calling with a life-threatening or psychiatric emergency, please call 911 or proceed to your nearest hospital. Email correspondence should only be used for the occasional transmission of agreed upon documents or to reschedule an appointment. Correspondence will become part of your medical file.

By signing below you indicate you have read, understand and agree to the above policies and have received a copy of this information.

Client Name: (Print) _____ Signature: _____ Date: _____