MALIKA KAPADIA, PSY.D.
LICENSED CLINICAL PSYCHOLOGIST
PSYCHOTHERAPY PRACTICE
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(585) 210.8488

The following information addresses issues of confidentiality, treatment, and policies of my practice. Please ask any questions you may have before signing this form.

Information that you provide during treatment will be kept confidential and released only with your consent. I do reserve the right to consult with my professional colleagues in a way that preserves your anonymity. There are several exceptions to confidentiality, which include (1) if you are at risk of hurting yourself or someone else, (2) if child or elder physical or sexual abuse is suspected, and (3) if a subpoena is issued by the court. In these cases I am ethically and/or legally bound to share information.

In January 2013, NY State passed legislation designed to limit a suicidal or homicidal person's access to fire arms. This law requires licensed psychologists to alert the County Director of the Office of Mental Health and the NY Department of Criminal Justice Services (DCJS) if you are likely to engage in conduct that will result in serious harm to self or others. If I believe that you may be in imminent danger of hurting yourself or someone else, if appropriate, I will need to alert the Director of Monroe County's Office of Mental Health, Kathleen Plum, Ph.D., RN, NPP. Dr. Plum would inform DCJS, who would identify whether you have a gun permit, and if so, take steps to remove your firearms. This law can also prevent you from obtaining a gun permit for five years following a report to the DCJS.

We will discuss the goals of treatment together. I cannot ethically guarantee the results of treatment, and your experience will be based in part on your commitment to treatment. Therapy can be a difficult process and while it can have beneficial effects, it can also elicit uncomfortable thoughts and feelings. If at any time you feel dissatisfied with the work we do together, I encourage you to discuss it with me so that we may find solutions that you find suitable.

You have the right to end treatment at your own discretion at any time. Ideally, ending will be a mutual decision. We can continue to discuss expectations for treatment and treatment length on an ongoing basis.

We will discuss fees at the onset of therapy. I ask that you pay your fees at the outset of each session. If payment is neglected, I reserve the right to discontinue treatment until the balance is met.

If you need to cancel an appointment, I ask that you give at least 24 hours advance notice by calling (585)210.8488. If you give less than 24 hours notice, I reserve the right to charge you the full cost for that visit.

I appreciate this opportunity to work with you and look forward to our work together. If you have any questions or concerns, please be sure to ask before signing below.

I have read and understood the above information, and all my questions have been answered.

_____ _____
Signature Date

_____
Print name

I have read and agree to the Notice of Privacy Practices posted in the waiting room. I authorize the release of medical information necessary to process insurance claims. I also authorize payment of medical benefits to Malika Kapadia, Psy.D.

_____ _____
Signature Date