
ANDREA KEITH, LMFT, CEAP

Psychotherapy and EAP Programs
Quality by Design

Post Office Box 53454
Irvine, CA 92619
akeithmft@gmail.com

3101 Pacific Coast Highway, Suite #407
Newport Beach, CA 92663
www.time4therapy.com

4199 Campus Drive, Suite #275
Irvine, CA 92612
www.pet-loss-therapy.com

949.650.2442

Treating Therapist: Andrea Keith, MFT, CEAP, CAMF
Licensed Marriage and Family Therapist #MFC45708 (LMFT)
Certified Employee Assistance Professional (CEAP)
State-Certified Domestic Violence Victim-Survivor Advocate
Certified Anger Management Facilitator (CAMF)
Probation-Approved Facilitator for Court-Ordered Batterer Intervention Groups
Certification in Grief, Loss, and Bereavement

EAP CLIENT AGREEMENT / INFORMED CONSENT

No information obtained in therapy sessions(s) is ever released to outside sources without written consent unless it pertains to your (1) being gravely disabled, (2) violent acts or imminent danger to yourself and/or others, including (3) suspected child, elder, or pet abuse, and (4) pursuant to a court order or legal action by you, against your therapist.

However, having been referred by your EAP, it is understood that your EAP and this provider are authorized by you to use, disclose and release to each other and exchange the following individually identifiable protected health information: (1) Assessment and treatment data; (2) Any information required or useful to have services authorized, obtain benefit coverage or obtain payment for services to or for me; (3) Any information required or useful for planning, providing or monitoring services for me; (4) Any information required or useful for administration of the EAP program and services. It is agreed that services can include psychotherapy, psychological assessment, and/or EAP. Services received will be consistent with generally established and acceptable good practice guidelines in the mental health profession.

It is the desire of this therapist that we have a good working relationship. Therefore, should you have any questions about such services, you are strongly encouraged to present and discuss them with this therapist. However, should it be in the best interest of therapy, or should you choose to terminate your therapy and seek services from another therapist/agency, this therapist will not be responsible or liable for your continued therapy. In addition, appropriate referrals will be provided to you upon your request.

The standard fee for psychotherapy service is covered by your EAP, and free to you. Each therapy session is based on a 50-minute hour. **If you are unable to keep a scheduled appointment, it is requested and appreciated that you notify this therapist at least 24-hours in advance. If you do not give a timely notice of cancellation**, one of your EAP sessions may be forfeited. With a 24-hour advance notice, I am able to schedule another client during your cancelled appointment time. This policy includes no-show appointments and/or late cancellations. All appointments must be made in advance.

In the event of an emergency, this therapist is authorized to contact emergency services (tel. 911) if necessary. You also authorize this therapist to contact the following person(s) in the event of an emergency and/or to leave appropriate messages on voice mail, with answering services, or with others who answer:

Emergency Contact: _____ Tel: _____

Emergency Contact: _____ Tel: _____

I understand and agree to the terms of this agreement.

Client's Signature

Therapist's Signature

Date

_____ File copy (1)

_____ Client copy (1)