Joslyn Cruz, Ph.D.

Licensed Psychologist

Informed Consent for Psychotherapy Services

Provider: Joslyn Cruz, Ph.D., Licensed Clinical Psychologist

Location: 68 South Main Street, Suite 200, West Hartford, Connecticut 06107

Contact: 860-325-2349 | JoslynCruzPhD@gmail.com

Please read carefully and sign below. A copy will be provided for your records.

Nature of Psychotherapy

You are engaging in outpatient psychotherapy with a licensed psychologist in private practice. Psychotherapy is a collaborative process designed to help individuals better understand themselves, their emotions, relationships, and patterns that may be contributing to distress or dissatisfaction.

My approach is primarily psychodynamic and attachment-based, informed by the belief that early experiences and relationships shape how we think, feel, and relate throughout life. I integrate elements of Dialectical Behavior Therapy (DBT), Emotionally Focused Therapy (EFT), Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), and narrative approaches when appropriate. Therapy may focus on insight, emotional awareness, coping strategies, relational patterns, and meaningful, sustainable change.

Psychotherapy can address concerns such as anxiety, depression, trauma, burnout, relationship difficulties, identity transitions, substance use patterns, and life stressors. While therapy can be highly beneficial, outcomes cannot be guaranteed.

Initial Sessions & Therapeutic Fit

Initial sessions typically last 50–60 minutes and include discussion of your concerns, personal history, current stressors, and goals for therapy. These sessions allow us to determine how I can best support you and whether this practice is a good fit for your needs.

Ongoing treatment is not guaranteed following the initial session(s). If it becomes clear that your needs would be better served elsewhere—due to level of care, scope of practice, or therapeutic fit—I will provide appropriate referrals. You are encouraged to ask questions at any point, as feeling comfortable and aligned in the therapeutic relationship is essential.

Therapy Sessions

Standard psychotherapy sessions are typically 50 minutes and occur weekly or at a mutually agreed-upon frequency (typically weekly or biweekly). Active participation, openness, and

consistency support the effectiveness of therapy. You are encouraged to share feedback about what feels helpful or challenging so the work can be adjusted as needed.

Confidentiality

All psychotherapy services are confidential and protected by HIPAA and Connecticut law. Information will not be released without your written consent except when legally required, including:

- Situations involving imminent risk of harm to self or others
- Suspected abuse or neglect of a child, elder, or vulnerable adult
- Court-ordered disclosure or legal subpoena

For adolescent clients, confidentiality is respected while also recognizing the important role of parents or guardians. Information may be shared with parents when clinically appropriate, with care taken to preserve the adolescent's trust and privacy.

Telehealth

Therapy may be provided via secure telehealth platforms when appropriate. Telehealth involves electronic communication and may be subject to technical limitations. Sessions will not be recorded without your consent.

In accordance with my current licensure, you must be physically located in Connecticut, New York, or Michigan during telehealth sessions and are responsible for ensuring a private, secure environment. Telehealth may not be appropriate for all clinical situations, and you may withdraw consent at any time without affecting your right to future care.

Fees, Payment & Insurance

This is a private-pay practice and does not accept insurance. Payment is due at the time of service.

- Individual psychotherapy (50 minutes): $250
- Fees may change with 30 days' notice
- Accepted forms of payment: cash, check, credit card, HSA, FSA, and Zelle

A superbill may be provided upon request for possible out-of-network reimbursement, which is the client's responsibility. If you are unable to pay for services due to a change in financial circumstances, please notify me as soon as possible. Failure to pay for services without communication may result in suspension or termination of treatment.

Cancellations & Missed Appointments

Appointments are reserved specifically for you. Please provide at least 24 hours' notice for cancellations.

- Late cancellations (less than 24 hours' notice) and missed appointments (no-shows) will be charged $125
- Repeated missed appointments or late cancellations may result in termination of services
- Exceptions may be made for emergencies at my discretion

Emergencies

This practice does not provide emergency or crisis services. In case of an emergency, please use one of the following resources:

- Call 911 or go to the nearest emergency room
- Connecticut Crisis Line: 1-800-HOPE-135 (1-800-467-3135)
- 988 Suicide & Crisis Lifeline (call or text 988)

Communication & Messages

You may contact me by phone or secure message for non-urgent matters such as scheduling or brief questions.

- Messages are typically returned within one business day
- Messages received on weekends or holidays will be returned on the next business day
- This practice does not provide after-hours, on-call, or crisis services
- Do not use voicemail, email, or text for urgent or emergency concerns

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Social Media & Online Policy

To protect your privacy and maintain professional boundaries, the following guidelines apply to online communication:

- I will not accept friend or connection requests from current or former clients on personal social media platforms
- Clinical care cannot be provided via social media, text message, or email; these channels are not secure and are not appropriate for clinical communication
- If you choose to communicate via email or text, please be aware that confidentiality cannot be guaranteed through those channels
- I may conduct limited internet searches only in situations where there is a clinical safety concern

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Risks, Benefits & Ending Therapy

Psychotherapy may lead to insight, growth, and symptom relief, but it can also involve discussing difficult emotions or experiences that may temporarily increase distress. Open communication about your experience is encouraged.

Either you or I may end therapy at any time. Therapy may be discontinued for reasons including:

- Nonpayment for services
- Repeated missed appointments or late cancellations
- Lack of therapeutic fit
- Boundary concerns or behavior that compromises the therapeutic relationship
- Clinical needs that exceed the scope of this practice

When clinically appropriate, reasonable notice and referrals to alternative providers or levels of care will be offered. Immediate termination may occur if client or provider safety is at risk.

Treatment of Adolescent Clients (Ages 14–17)

This practice sees adolescent clients ages 14 and older. Special considerations apply when treating minors:

- A parent or legal guardian must provide consent for treatment of clients under 18 and must sign this form
- Adolescents age 14 and older have a right to a degree of confidentiality; information shared in sessions will generally be kept private, except where disclosure is required by law or necessary to protect safety
- I will discuss with both the adolescent client and guardian what information will and will not be shared, to support a trusting therapeutic relationship while keeping the family appropriately informed
- Connecticut law permits minors to consent to certain services independently in limited circumstances; I will notify you if this applies

The goal is to balance the adolescent's developing autonomy with the family's appropriate involvement in care.

Consent to Treatment

By signing below, you acknowledge that:

- I understand the nature, purpose, risks, and limitations of psychotherapy, including telehealth
- I have had the opportunity to ask questions and receive answers
- I consent to receive psychotherapy services from Joslyn Cruz, Ph.D.
- I agree to the policies outlined above regarding payment, attendance, communication, and participation

Client Name (printed): ____

Client Signature: ____

Date: ______________________________

If client is a minor (under 18), parent or legal guardian must also sign below.

Guardian Name (printed): ____

Relationship to Client: ____

Guardian Signature: ____

Date: ______________________________

Provider Signature: ____

Date: ______________________________