

## **Disclosure Statement & Consent for Services**

### **Introduction**

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

### **Information about Your Therapist**

Your therapist will discuss his professional background with you and provide you with information regarding his experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience and professional orientation. Your therapist is a Marriage and Family Therapist licensed by the state of California. His license number is LMFT 82993.

### **Fees and Insurance**

The fee for service is \$140 per 50-minute individual session, \$90 per 30 minute children's session, and \$160 per family, or marital/couples therapy session. There is an additional fee of \$5.00 for credit card transactions to cover service fees. Fees are payable at the time services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure.

Please inform your therapist if you wish to utilize health insurance to pay for services. If your therapist is a contracted provider for your insurance company, your therapist will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist is happy to assist your efforts to seek insurance reimbursement, he is unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with your therapist.

If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

### **Confidentiality**

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family or marital/couples therapy. This

means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him, when working with other members of your family. Please feel free to ask your therapist about his “no secrets” policy and how it may apply to you.

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person or when a client is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the client that the FBI sought or obtained the items under the Act.

### **Minors and Confidentiality**

Communications between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child’s treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his professional judgment, may discuss the treatment progress of a minor client with the parent or caretaker. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

### **Privacy Policy**

By signing below, you acknowledge receipt of therapist’s Notice of Privacy Practices. This document provides information about how therapist may disclose your private health information. Please read it carefully. This document is subject to change. If changed, you will receive a revised Notice of Privacy Practices. If you have left treatment, you may obtain the revised notice from the therapist.

### **Appointment Scheduling and Cancellation Policies**

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hours in advance of your appointment. If you do not provide your therapist with at least 24 hours notice in advance except in case of sudden illness or family emergency, you are responsible for payment for the missed session.

### **Therapist Availability/Emergencies**

Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions.

You may leave a message for your therapist at any time on his confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during normal workdays (Monday through Friday) within 24-48 hours. If you have an

urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail.

**In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.**

You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis:

Crisis Hotline: (800) 479-3339

Youth Shelter: (760) 721-8930

Domestic Violence Help: (888) 272-1767

Hospital: (760) 633-6501

### **About the Therapy Process**

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion. Due to the varying nature and severity of problems and the individuality of each client, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

### **Termination of Therapy**

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Your signature indicates that you have read this agreement for services carefully and understand its contents.

Please ask your therapist to address any questions or concerns that you have about this information before you sign!

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Client's Signature

Date: \_\_\_/\_\_\_/\_\_\_