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Contract for Psychotherapeutic Services

Consent for Treatment Form

The following information describes the operating procedures of Patricia Jones' practice. Please read it over carefully. If you have any questions, I will be happy to answer them. Please keep a copy of this form for future reference.

I. The Therapy Process

Participating in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part and may result in your experiencing considerable discomfort. Change will sometimes be easy and swift, but more often it will be slow and frustrating. Remembering unpleasant events and resolving them through therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended. When working with children, behavioral symptoms often increase before positive changes occur. As part of the therapeutic process, I may use several techniques including but not limited to talk therapy, art, play, sandplay, suggestions for reading, and homework assignments.

II. Confidentiality & Exceptions

Your discussions with me as a California Licensed Marriage and Family Therapist are confidential, which means our discussions are protected by law. Every effort is made to protect the confidentiality of your treatment. All information is held strictly confidential unless written approval is obtained. Please note the following exceptions:

- 1) If you sign an authorization to exchange confidential information form or release of information form giving permission to me and/or other professionals to share information.
 - 2) If you are in clear and immediate danger of harming yourself, another person, or their property.
 - 3) I have substantial reason to believe that a minor, elder, or dependent adult is at risk or has been abused. In this situation I am legally mandated to report to Social Services.
 - 4) If you are unable to provide basic care for yourself.
 - 5) If I am subpoenaed or court-ordered to release information as part of a legal proceeding.
- Please note that if you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by your therapist.

6) Certain law enforcement agencies (e.g. Homeland Security, FBI, etc.) have the right to inspect your psychotherapy records without notifying you.

7)* Insurance billing or authorization process often requires a diagnosis, treatment plan, and other confidential information.

In such situations, information may only be released to designated individuals or agencies. From time to time I participate in professional, clinical, or legal consultation in order to improve my work with you. In these casings, your identity remains anonymous. If you have concerns about whom I consult with, please let me know. Since confidentiality is so vital to successful therapy, I do all that is possible to maintain it.

I am required to keep records including a clinical record, bookkeeping - fee record, and psychotherapy progress notes. These are confidential and are kept in a locked file cabinet with security on the building. Records are kept for at least 7 years (7 years past minor client turning 18) and then destroyed. You have certain rights concerning your records. Please discuss these with me.

* For your information, insurance companies may transfer information about you to a data base with a national medical information data bank - Medical Information Bureau (MIB) - that may put confidentiality at some risk. [You can check accuracy of their file by calling 866.692.6901 or visiting their website at www.mib.com/html/request_your_record.html]

III. About therapy

The standard therapy session is 50 minutes. If you arrive late, we will have less time in which to work and progress may be delayed. I will keep track of the session time and remind you when the session is about to end. Please be advised that in rare circumstances there may be a time when the session before yours is running late due to an unexpected crisis. In such cases, I ask that you be patient and considerate. I will make every effort to compensate you for any time taken from your therapy session.

Longer sessions which can be arranged upon request, or I might suggest longer sessions for certain clinical issues. Family or couples' therapy often works best with longer sessions. The fee will be adjusted accordingly. Clients often wonder how long the course of therapy should be. The length of time is variable, based on your goals and mutual agreement. I usually meet with you for a regularly scheduled appointment once a week. Our first three meetings provide us with time to become acquainted and decide a plan for therapy or refer you if necessary. Once we have agreed to work together, I ask that you not leave therapy suddenly. It is important to allow time for summary and closure.

Your relationship with me is professional and therapeutic. In order to preserve this relationship, it is imperative that I not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. I care about helping you, however, I am not in a position to be your friend or to have a social, personal, or business relationship with you. gifts, bartering and trading services are not allowed under the ethical regulations of my profession.

IV. Scheduling and Fees

When you make an appointment I reserve that time for you alone. Because consistency is important in therapy, I ask you to notify me at least 24 hours in advance for rescheduling or can-

celing an appointment. If you are going to be late to your appointment, please call me through the answering service to inform me. I won't wait beyond 20 minutes into a failed appointment. I charge the full fee for a missed appointment or one that is canceled in less than 24 hours. Exceptions to the 24 hour notice are dire emergencies or sudden illness. Please note that excessive late cancellations will incur a fee regardless of cause. Insurance companies and other third party payers will not cover this late cancellation fee so if you are using insurance you personally will need to pay late cancellation or failed appointment fees. You are not charged for any appointments missed due to my absence and I will make every effort to notify you in advance of any cancellations, changes, or vacations.

You are financially responsible for payment and I require payment at the time of service. For those paying with insurance, please pay your copayment at time of service. Occasionally special circumstances arise which makes it difficult for clients to follow the usual procedures for payment. Please feel free to discuss your concerns with me, as other arrangements may be possible. Any returned check bank fees are also your responsibility to pay. My current fee is \$85.00 per 50 minute session, or the amount negotiated by your insurance company if I am contracted with them. I charge a higher fee for couples and families. I occasionally recommend longer sessions if clinically appropriate. We will need to discuss the larger fee for longer sessions since insurance often will not cover this. If I increase my fee, I will discuss any increases with you in advance. If you are unable to afford the standard fee, check to see if my several sliding scale spaces are currently filled.

V. Insurance

If you have health insurance you wish to bill, remember that professional services are rendered and charged to you, the patient, and not to the insurance company. As a courtesy I do bill insurance companies. By signing this form you are authorizing me to bill your insurance company on their required forms and to give them any required information they may require for authorization and/or billing purposes. You are also agreeing to pay me the full fee if they fail to do so. You are also agreeing to pay for sessions yourself after your insurance authorized sessions reach your policy limits. Please know your policy so you can give me accurate information about the level of coverage and whether pre authorization is required. If the latter is required, you will need to make that arrangement with your insurance company and bring the necessary paperwork with you to your first session. You may also need to provide me with a doctor's referral, billing address, and phone number for the insurance company and policy numbers. I will also need your social security number for my intake form as some insurance companies still require it if I should need to call them with a billing question. Please bring your insurance card to the first session so I can make a copy of both sides for my records, or bring a clear copy - both the front and back. Upon your request, I will provide you with a copy of insurance billings and/or a monthly statement. Note, due to government regulations, I cannot accept Medicare insurance. If you switch to Medicare insurance, please notify me immediately so we can discuss referring you to an LCSW or Clinical Psychologist.

VI. Messages and Emergencies

I am in my office Monday through Thursday (occasional Fridays) although my schedule varies. During weekdays I check my phone messages regularly during weekdays and make an effort to return your call as soon as I can. If you need to contact me by phone, do not hesitate to call my confidential voice mail 707.445.4183. When you leave a voice mail message, I am usually able to return calls within one business day or on Monday following weekend calls. If you feel you are

in an emergency, and especially if you are at risk either to yourself or others, please go to the nearest emergency room for immediate attention. In the event of an emergency related to therapy, please leave a voice mail at the office number above and also call my answering service at 707.441.2229. Any emergency call or phone consultation with me lasting longer than 10 minutes will be considered a phone therapy session and will be charged on a prorated basis according to the time spent talking. Insurance plans usually do not cover this. When I am on vacation another licensed therapist will provide emergency coverage. You will need to pay that clinician's fees directly to her or him if you use these services.

VII. Freedom to Withdraw

You have the right to choose NOT to receive therapy from me. If you choose this, I will provide you with the names of other qualified professionals whose services you might prefer. You have the right to terminate therapy at any time without any financial, legal, or moral obligations other than those you've already incurred. I have the right to terminate therapy with you if I believe that therapy is no longer beneficial to you, if I believe that you will be better served by another professional whom I will recommend, when you have not paid for the last two sessions unless special arrangements have been made, or when you have failed to show up for your last two therapy session without a 24 hour notice. If any of these situations apply, I will send you a certified letter to your address of record to inform you of the decision and I will give you the names of several therapists for your future counseling needs.

VIII. Consent to Treatment

I/we understand and consent to the therapeutic treatment as described. This consent shall be valid for the duration of psychotherapy. By signing this form I/we acknowledge that I/we have both read and understand all the terms and information contained herein. Ample opportunity has been offered me to ask questions and seek clarification of anything unclear to me.

Print Name _____

Signature _____

Date _____

Client's Representative if applicable - name, signature, relationship:

Therapist Signature _____ Date _____

FOR INDIVIDUALS, PRINT ONLY THE FIRST 4 PAGES, SIGN, AND BRING TO YOUR FIRST SESSION

FOR COUPLES, FAMILIES, OR MINORS (CHILDREN UNDER 18), PLEASE PRINT ALL 7 PAGES AND SIGN AS INDICATED. IF YOU CHOOSE TO MAIL THIS TO MY OFFICE, BE SURE TO PUT SUFFICIENT POSTAGE.

Consent for Couples or Family Therapy

As a couple/family we agree to engage in therapy which will include both joint and individual sessions. I understand my right to confidentiality in individual sessions, but am willing to waive that right so that information shared in individual sessions can be shared in joint session at the discretion of the therapist.

I also understand that my therapist believes that couple/family therapy is most successful when a family is willing to be completely honest with the therapist and with each other. For this reason, my therapist has explained that she is unwilling to collude with secrets. Where a family member shares information with the therapist it will be discussed in joint sessions to maintain an atmosphere of openness and honesty.

I authorize and request Patricia Jones to carry out psychological examinations, diagnostic procedures, and/or treatments that are advisable now or during the course of my care as a patient.

I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I have read and fully understand this Consent for Treatment Form.

Date _____ Family Member Signature _____

Date _____ Family Member Signature _____

Date _____ Family Member Signature _____

Date _____ Family Member Signature _____

Date _____ Family Member Signature _____

Date _____ Family Member Signature _____

Date _____ Therapist's Signature _____

Consent to Treat Minor

I am required to have a signature from both parents or legal guardians.

I am also required to have a copy of your current custody agreement on file if you are legally divorced or separated from your child's other parent. Please bring it to the first session.

Should there be any litigation regarding your child in treatment, I require that confidentiality be respected and that I be immune from subpoena. The same requirement applies to treatment records. The purpose of this policy is to protect your child's emotional safety by not betraying him or her when s/he has been told that his/her statements in therapy are private and confidential. Any matter brought to my attention by either parent regarding the child may be revealed to the other parent. Because parents are not my client (when doing treatment for minor children), parents are not entitled to patient - psychotherapist privilege. In the event of a subpoena for my records I will invoke privilege on behalf of my child client. The same privilege does not apply to parents since parents are not considered to be my clients unless I am providing family therapy. Parents are therefore not protected by confidentiality or patient - psychotherapy privilege.

This psychotherapy will not yield recommendations about custody. Such recommendation can only be offered after a thorough custody evaluation. The purpose of treatment is incompatible with such an evaluation. Treatment and evaluation are separate services. Evaluation does not include confidentiality. Information is being gathered for a third party with a focus on answering specific questions to help the courts make an informed decision about custody or placement.

I may be asking you for consents to share or receive information from teachers, day care providers, doctors, etc. who might have experiences to share that will benefit treatment. No information is shared or received without both of the parents' and child's prior knowledge.

Effective therapy begins with the establishment and maintenance of a safe and protected place for the child to express, question, or act out whatever is troubling her/him. The establishment and maintenance of that emotional and physical safety rests on the child's guarantee of privacy and confidentiality. The only exception to this is the legal requirement that I report abuse.

The focus of treatment is healing, recovery, or the mastery of behavior problems. The only needs considered are those of the child. The treatment plan is tailored to the specific needs of the child. This promotes the child's sense of therapy as a special and private place designed for the well being of the client.

While I discuss your daughter's/son's progress and treatment plan, I do not share specific statements made by the child or specific behaviors acted out by him/her. It is understood that if treatment is being requested, both parents, whether separated or living together, will receive the same information about their son/daughter. Consent is required from both parents. To treat a child without dual parental consent places the youngster in an alliance with the parent who brings her/him to therapy. This is very stressful for the child. She/he is burdened with the necessity of keeping secret from the other parent. Ethical standards prohibit and child therapist from triangulating a child.

Lastly, it is important that you wait in the waiting room for you child. If you need to leave during your child's session, you must be timely in picking your child up after her/his session. I

cannot wait with your child for your return. Leaving young children in the waiting room alone is often both uncomfortable and frightening which are both detrimental to our work in counseling. 1. I generally require the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of a parent or caregiver to give consent for psychotherapy, I will require copies of supporting legal documentation, such as a custody order, prior to the commencement of services.

Since we often use art and play materials in therapy with children, please dress your child in clothing appropriate for messy play.

I _____ as parent/guardian of minor child named
_____ (child's name)

authorize and request Patricia Jones to carry out psychological examinations, diagnostic procedures, and/or treatments that are advisable now or during the course of his/her care as a patient. I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I have read and fully understand this Consent for Treatment Form.

Date _____ Minor's Signature _____

Date _____ Parent/Guardian Signature _____

Date _____ Parent/Guardian Signature _____

Date _____ Therapist's Signature _____