

Disclosure Statement & Agreement 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 any questions that you may have regarding its contents.

Information about this practice

The individual who operates this practice is:

Carolyn Berry M.A., MFT

License # MFC 28911

Fees

The fee for service is \$_____ per individual session.

Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure.

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 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. (In addition your therapist will not disclose information communicated privately to her by one family member, to another family member without written permission.)

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

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.

Disclosure Statement & Agreement for Services

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 her, when working with other members of your family. Please feel free to ask your therapist about her “no secrets” policy and how it may apply to you.

Minors and Confidentiality

Communications between therapists and patients 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 her professional judgment, may discuss the treatment progress of minor patients with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have this topic with their 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 hrs. in advance of your appointment. If you do not provide your therapist with at least 24 hours notice in advance, 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 her 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 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message.

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.

Disclosure Statement & Agreement for Services

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

- L.A. County Mental Health/Crisis Line.....800-854-7771
- Women and Children Crisis Shelter.....562-945-3939
- Alcohol and Drug Helpline.....800-821-4357
- Domestic Violence Help.....800-978-3600
- Child Abuse Hotline.....800-540-4000

Therapist Communications

Your therapist may need to communicate with you by telephone, email, or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

- My therapist may contact me at my home. My home phone # is: () _____.
- My therapist may call my cell phone. My cell phone # is: () _____.
- My therapist may call me at work. My work phone # is: () _____.
- My therapist may send a fax to me. My fax number is # is: () _____.
- My therapist may communicate with me by email. My email address is:

About the Therapy Process

It is your therapist 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. Therapist and patient are partners in a 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 patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Disclosure Statement & Agreement for Services

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!

Name of Patient

Date: ____/____/____