**AGREEMENT FOR SERVICE / INFORMED CONSENT**

This Agreement is intended to provide \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (herein “Patient”) with important information regarding the practices, policies and procedures of Maitri Counseling, Silvia Dominguez-Rios Licensed Marriage and Family Therapist (herein “Therapist”), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

## **Policy Regarding Consent for the Treatment of a Minor Child**

Therapist generally requires the consent of both parents/caregivers prior to providing any services to a minor child. If any question exists regarding the authority of Representative to give consent for psychotherapy, Therapist will require that Representative submit supporting legal documentation, such as a custody order, prior to the commencement of services.

**Information About Your Therapist**

Therapist is in private practice as a licensed marriage and family therapist (LMFT), working mostly with individuals and families. Therapist has extent experience working with victims of crime, survivors of abuse or domestic violence and people suffering from the effects of family traumas. Therapist is also certified in Trauma-Focused Cognitive Behavioral Therapy and Corrective Experience Focused Therapy. Therapist draws wisdom from Experiential, Interpersonal and Acceptance based theories as well as Mindfulness stress reduction techniques.

 **INFORMED CONSENT**

**Risks and Benefits of Therapy**

Psychotherapy is a process in which Therapist and Patient discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as any problems or difficulties Patient may be experiencing.

Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, including an active participation in the therapeutic process, honesty, and a willingness to change thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Patient’s perceptions and assumptions, and offer different perspectives.

The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationships is the responsibility of Patient.

During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Patient should address any concerns he/she has regarding his/her progress in therapy with Therapist.

**Transfer Plan**

In the case of incapacitation, termination of practice or death of Therapist, your file and information will be assigned to a designated Records Custodian who will contact you to provide continuation of services or help you find another therapist.

**Confidentiality (Please read/sign separate acknowledgment to Limits of Confidentiality)**

The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.

**Professional Consultation**

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Patient.

**Records and Record Keeping**

Therapist may take notes during session, and will also produce other notes and records regarding Patient’s treatment. These notes constitute Therapist’s clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any patient. Should Patient request a copy of Therapist’s records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Therapist will maintain Patient’s records for ten years following termination of therapy. However, after ten years, Patient’s records will be destroyed in a manner that preserves Patient’s confidentiality.

**Couples and Family Therapy**

In the case of couples or family therapy, the relationship between the individuals is considered the Patient. Therapists are not obligated to hold confidences between partners or family members. Should one of the members of the couple/family give information without the others being present, Therapist reserves the right to use her professional judgment regarding confidentiality between the parties involved. If a partner or family member is not willing to reveal confidences, couples/family therapy may be contra-indicated and Therapist may terminate couples/family therapy.

Initials here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Electronic Communications**

It is impossible to guarantee the confidentiality of email or text messaging content. By initialing here you grant Therapist permission to email and text you. You acknowledge the risks and release Therapist from liability for the risk to your confidentiality. Therapist typically returns emails and text messages within 48 hours during the week. Emails and texts should be limited to administrative issues such as scheduling or billing questions. Therapist does not accept friend requests from clients on Facebook, Linked In or other social media website.

Initial/s here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Therapist has access to billing software and client information and have signed a strict confidentiality agreement to protect client information. By initialing here, you acknowledge that Therapist will have access to your client file for the purpose of billing and other administrative tasks.

Initial/s here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**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, in the exercise of her professional judgment, Therapist may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors, and their parents, are urged to discuss any questions or concerns that they have on this topic with their therapist.

Full name/s and date/s of birth of minors to receive treatment:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychotherapist-Patient Privilege**

The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient’s behalf until instructed, in writing, to do otherwise by Patient or Patient’s representative. Patient should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

**Fee and Fee Arrangements**

The usual and customary fee for psychotherapeutic service is $120.00 per 50-minute session. Clinical interviews required for psycho-social reporting fee is $150.00 per 60 minutes and each 60-minute hour thereafter in preparation for a written report. Sessions/interviews longer than 60-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust fees and Patient will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payers, or by agreement with Therapist.

The agreed upon fee between Therapist and Patient is $\_\_\_\_\_\_. Therapist reserves the right to periodically adjust fee. Patient will be notified of any fee adjustment in advance. Patients are expected to pay for services at the time services are rendered. There will be a $25 charge for payment returned as non-sufficient or non-payable. Therapist accepts cash, checks, and major credit cards, including Visa, MasterCard, Discover and AmEx.

Initial/s here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

From time-to-time, Therapist may engage in telephone contact with Patient for purposes other than scheduling sessions or coordination of care with other professionals. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at Patient’s request and with Patient’s advance written authorization regarding treatment. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes.

Initial/s here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Insurance**

Patient is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payer. Patient is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles. At the time of this agreement, Therapist is a contracted provider with the following companies: CalVCP and has agreed to a specified fee. If Patient intends to use benefits of his/her health insurance policy, Patient agrees to inform Therapist in advance. If/When Therapist is not a contracted provider with Patient’s insurance company or managed care organization, should Patient choose to use his/her insurance, Therapist will provide Patient with a statement, which Patient can submit to the third-party of his/her choice to seek reimbursement of fees already paid.

Initial/s here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Cancellation Policy**

Patient is responsible for payment of the agreed upon fee for any missed session(s). Patient is also responsible for payment of the agreed upon fee for any session(s) for which Patient failed to give Therapist at least 24 hour notice of cancellation. Cancellation notice should be left on Therapist’s voice mail at (916)844-2256 or any other number given for texting and/or emailing.

Initial/s here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Walk-Talk Therapy**

When and if therapist and patient consider it useful, therapy can be conducted outside the office. Patient hereby acknowledges and agrees that therapist is not or will not under any circumstances be liable for accidents and/or confidentiality issues that arise on such walk-talks.

Initial/s here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Patient Litigation**

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient and another individual, or entity, are parties. Therapist has a policy of not communicating with Patient’s attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient’s legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Patient agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has herself available for such an appearance at Therapist’s usual and customary hourly rate of $120.00.

**Therapist Availability**

The easiest way to reach Therapist is by email at silvia@maitricounseling.org. You may leave a message for Therapist at any time on her confidential voicemail at (916) 844-2256. If you wish 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 48 hours. **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 or go to the nearest hospital emergency room.**

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

Sutter Center for Psychiatry: 1-800-801-3077

Sacramento County Mental Health Treatment Center: 916-875-1000

Suicide Prevention Hotline: 916-372-6565

California Youth Crisis Line: 1-800-845-5200

Domestic Violence Crisis Line (WEAVE): 916-920-2952

**Therapist Communications**

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

\_\_\_\_My therapist may call me at my home. My home ph number is: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_My therapist may call me on my cell phone. My cell ph number is: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_My therapist may call me at work. My work ph number is: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_My therapist may send mail to me at my home address.

\_\_\_\_My therapist may send mail to me at my work address.

\_\_\_\_My therapist may communicate with me by email.

 My email address is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_My therapist may send a fax to me. My fax number is: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Termination of Therapy**

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of Therapist’s scope of competence or practice, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion.

Upon either party’s decision to terminate therapy, Therapist will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient.

**Acknowledgement**

By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Patient’s satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Patient agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, which may result from such treatment.

**Patient/s Full Name/s (Print and Sign):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Signature of Patient (or authorized representative) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Signature of Patient (or authorized representative) Date

**Name/s and Signature/s of Responsible Party/Parents/Caregivers (Print and Sign):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please print) Responsible party/Parent/Caregiver (Signature and date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please print) Responsible party/Parent/Caregiver (Signature and date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist: Silvia Dominguez-Rios, M.S., LMFT-78249