



# La Vie Counseling Associates

## **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**

At an appropriate time, your therapist will discuss his/her professional background with you and provide you with information regarding his/her 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.

Note: The therapist should indicate his/her licensure status before the patient completes this form.

Your therapist is a \_\_\_\_ **Licensed Marriage and Family Therapist** \_\_\_\_ **Marriage and Family Therapy Intern**

## **Fees and Insurance**

The fee for service is \$ \_\_\_\_\_ per individual therapy session.

The fee for service is \$ \_\_\_\_\_ per conjoint (marital/family) therapy session.

The fee for service is \$ \_\_\_\_\_ per group therapy session.

Individual sessions and conjoint (marital/family) sessions are approximately 50 minutes in length.

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 to consider any options that may be available to you at that time.

Please inform your therapist if you wish to use health insurance to pay for services. If your therapist/provider is a contracted provider for your insurance company, your therapist/provider 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/provider is happy to assist your efforts to seek insurance reimbursement, we are 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.

## **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.

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 patient presents a serious danger of physical violence to another person or when a patient 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 prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

## **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 his or her professional judgment, 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.

**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, you are responsible for a 50% payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions.

\_\_\_\_\_ **Initial here if this section has been read and understood.**

**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/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 and follow any instructions that are provided by your therapist's voicemail. In the event of a medical emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

**Therapist Communications**

Your 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 your 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 phone number is: \_\_\_ - \_\_\_ - \_\_\_\_\_

\_\_\_ My therapist may call me on my cell phone. My cell phone number is: \_\_\_ - \_\_\_ - \_\_\_\_\_

\_\_\_ My therapist may call me at work. My work phone 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: \_\_\_\_\_

**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 patients 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 patient, 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!

Signature: \_\_\_\_\_

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