Franci Smith, M.S., MFT, LPCC

Licensed Marriage and Family Therapist
Licensed Professional Clinical Counselor

PSYCHOTHERAPY INFORMED CONSENT, GENERAL INFORMATION AND OFFICE POLICIES

INTRODUCTION

This agreement is intended to provide clients with important information regarding the practices, policies and procedures of this office, and to clarify the terms of the professional therapeutic relationship between therapist and client. Any questions or concerns regarding the contents of this agreement should be discussed with Franci Smith prior to signing it.

BENEFITS AND RISKS OF THERAPY

Psychotherapy has both benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience some uncomfortable feelings. On the other hand, psychotherapy has also been shown to have many benefits, leading to better relationships, solutions to specific problems, and significant reductions in feelings of hopelessness and distress. However, there are no guarantees of what you will experience.

CONFIDENTIALITY AND EXCEPTIONS

Information shared by you in a therapy session will be kept in strict confidence. If I need to talk about your case with another source, first I will need to sign a "release of information" form. The exceptions to this are:

- When there is reasonable suspicion of abuse/neglect to a child, dependent, or elder adult. I am legally required to report this to the authorities.
- When the client communicates a serious threat of bodily injury to others.
- When the therapist has reasonable belief that the client may be a danger to themselves, others, or property of others.
- If you participate in marital or family therapy, information will not be disclosed about your treatment unless all parties provide their written authorization to release. In addition, information shared with me in and individual session while participating in marital or family counseling will ot be held confidential between family members.
- When disclosure is otherwise required by law.

There are two situations in which I might talk about part of your case with another therapist. I ask now for your understanding and agreement to do so in these two situations:

First, when I am away from the office for a few days, I may have another therapist "cover" for me. This therapist will be available to you in emergencies. Therefore, he or she needs to know about you. Of course, this therapist is bound to the same laws and rules as I am to protect your confidentiality.

Second, I sometimes consult with other therapists or other professionals about my clients. This helps me in giving high-quality treatment. These persons are also required to keep your information private. Your name will never be given to them, and they will be told only as much as they need to know to understand your situation.

Fees and Insurance

__Fees__: **Fees are due and payable at each session by cash, check or credit card.** A sliding scale rate is available for certain financial circumstances. Fees are increased each year by approximately 5%.

Upon request, monthly statements reflecting payment history can be generated for clients' personal records. Clients will be charged $35.00 for each check returned due to insufficient funds. Additionally, fees will be charged for services performed outside the therapy session (ie. Letters, reports, school meetings, phone consultations, collaborating treatment, etc.), which will be based on the therapist's standard 50 minute session rate and prorated if necessary.

The normal fee for psychotherapy and consultation services is $ 120.00 per 50 minute session. This fee may be renegotiated by either client or therapist as circumstances warrant. Fees are increased each year by approximately 5%. Clients will be given advanced notice of at least one month prior to the increase taking effect.

__Insurance Information__: In circumstances where a third party payer is financing treatment the signature on this document serves as authorization for this therapist to release pertinent information regarding client treatment as requested by his or her insurance company so
that the claim can be processed. This may include dates of service, diagnosis, and treatment summary. If this therapist is not a provider for a particular insurance company a monthly client statement may be generated so that clients can submit claims on their own behalf.

Some insurance companies will reimburse for out-of-network mental health therapy. I will provide you with a "receipt for services" form to submit to your insurance at the end of the month.

Scheduling Appointments and Cancellation Policy

__Scheduling of Sessions:__ Therapy sessions are scheduled to occur once per week at the same day and time, if possible. A different amount of therapy may be suggested by me depending on the severity of the issues being addressed.

__Short-Notice Cancellation__: I have a 24 hour cancellation policy. With less than 24-hours notice, you will be charged for your appointment. There are no exceptions to this policy.

__No-Show__: If you do not show up for a scheduled appointment (that you had not called to cancel with at least 24-hours notice, you will be charged the full fee for the session.

Should a client accumulate a total of two late cancellations or no-shows during the course of treatment, this therapist has the right to refer out to another therapist. In addition, if the client is 20 minutes late to a scheduled session, the therapist reserves the right to cancel the session and charge the client her hourly rate for a missed session.

Availability, Telephone and Emergency Procedures

I maintain a confidential voicemail system and check my messages regularly during business hours, Monday through Friday, from 10:00 a.m. to 6:00 p.m. at **(925) 588-3070.** I will return your call as soon as possible. Please note that I am not available on the weekends and will return calls the following Monday. As I am not always available for immediate response, **in the event of a medical or mental health emergency or an emergency involving a threat of 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 those who are in crisis:

Contra Costa Crisis Line: 1-800-833-2900
Youth Shelter: 1-800-843-5200
Rape Crisis Hotline: 1-800-656-4673
Domestic Violence Hotline: 1-888-215-5555

Legal proceedings

This therapist will not participate in any civil or legal proceedings of any kind, including but not limited to, child custody evaluations/reports, divorce proceedings, mental health evaluations, etc.

About the therapy process

It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I 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, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

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. I will discuss a plan for termination with you as you approach the completion of your treatment goals.

I will be happy to address any questions or concerns regarding the above information.

Thank you,

Franci Smith

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PSYCHOTHERAPY INFORMED CONSENT

Name of Client (s):____

Date(s) of Birth: _____________________________

THE FOLLOWING FEES ARE AGREED UPON:

INDIVIDUAL THERAPY **$**______________

FAMILY THERAPY **$** ______________

COUPLES THERAPY **$** ______________

ACKNOWLEDGEMENT/SIGNATURE

- I have thoroughly read and fully understand the Informed Consent pages of this document and have had my questions answered to my satisfaction.
- I accept, understand, and agree to abide to the contents and terms of this agreement.
- I understand that I am financially responsible for charges incurred.
- I authorize Franci Smith, MFT to provide psychotherapeutic treatment.
- I further agree to release of my records only as necessary to third party payers.

____
Client's Name

____
Client's Name

____ __________
Signature of Client (or person acting for client) Date

____ __________
Signature of Client (or person acting for client) Date

Relationship to client:
___Self ___Parent ___Legal Guardian
___Health care custodial parent of a minor (less than 1 years of age)___Other person authorized to act on behalf of this client

CONTACT PHONE NUMBER(S)_______________________________________

E-MAIL(S):____