



AGREEMENT FOR SERVICE / INFORMED CONSENT

Directions: *Please initial and sign the following form. We will review it at the first session.*

INTRODUCTION

This Agreement is intended to provide clients and/or representatives:

 [Name of client or client/s including minor child or children]

 [Name of parents and/ or guardians, representative/s]

(herein "Client/s or Representative/s") with important information regarding the practices, policies and procedures of Denise J. Hockley, LMFT, CATC (herein "Therapist"), 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 the Therapist prior to signing it. Please read and initial now, and sign document where designated during the initial intake session.

POLICY REGARDING CONSENT FOR THE TREATMENT OF A MINOR CHILD

Denise Hockley, LMFT, CATC generally requires the consent of **both parents** 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 the Parent(s)/Guardian(s) submit supporting legal documentation, such as a custody order, **prior** to the commencement of services. _____

THERAPIST BACKGROUND AND QUALIFICATIONS

Denise J. Hockley received her MS in Counseling Education from San Diego State University and was licensed on 12-11-1992 by the Board of Behavioral Science Examiners. Her License number is MFC 30255. Ms. Hockley is a Certified Addictions Treatment Counselor. Her Certification # is H1006130932. Ms. Hockley is a Clinical Member of the California Association of Marriage and Family Therapists in good standing.

RISKS AND BENEFITS OF THERAPY

Psychotherapy is a process in which your Therapist and you discuss a variety of issues, events, experiences and memories for the purpose of creating positive change so that you can experience your life more fully. It provides an opportunity to better and more deeply understand yourself, as well as, any concerns you may be experiencing and is a joint effort, sometimes including other family members. Progress and success may vary depending upon both the presenting problem and your motivation.

Participating in therapy may result in a number of benefits to you, 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, school, work, and family settings, increased capacity for intimacy and increased self-confidence. Such benefits may also require substantial effort on your part, (as well as caregivers and/or family members) to be an active participant/s in the therapeutic process. This includes honesty, and a willingness to change feelings, 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 your therapist will challenge your perceptions and assumptions, and offer different perspectives. The issues presented by the client may result in unintended outcomes, including changes in personal relationships. You should be aware that any decision on the status of your personal relationships remains your responsibility.

During the therapeutic process, many clients find that they feel worse before they feel better. This is not unusual. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. You should address any concerns you have regarding your progress in therapy with Ms. Hockley, LMFT, CATC. _____

PROFESSIONAL CONSULTATION

Professional consultation is an important component of a healthy psychotherapy practice. This means Ms. Hockley regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Ms. Hockley will not reveal any personally identifying information in regard to any client.

SECRETS POLICY

Ms. Hockley maintains a “no secrets” policy with couples and families meaning that I will not keep secrets from family members if I deem it counterproductive to your treatment plan. In other words, if I am treating the whole family, the whole family is the treatment unit rather than an individual. Individual therapy may be an option if a secret needs to be kept for safety reasons. _____

RECORDS AND RECORD KEEPING

Ms. Hockley may take notes during session, and will also produce other notes and records regarding your treatment. These notes constitute Ms. Hockley’s clinical and business records, which by law, she is required to maintain. Such records are the sole property of Ms. Hockley. She will not alter her normal record keeping process at the request of any client. Should you request a copy of your Therapist’s records, such a request must be made in writing. Ms. Hockley reserves the right, under California law, to provide you with a treatment summary in lieu of actual records. Ms. Hockley 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. Ms. Hockley will maintain your records for ten years following termination of therapy or for a minor, when Client is 21 years of age, whichever is longer. However, after ten years, your records will be destroyed in a manner that preserves client confidentiality. _____

CONFIDENTIALITY

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

In regards to therapy with a minor, Representative (s) should be aware that Therapist is not a conduit of information from Client. Psychotherapy can only be effective if there is a trusting and confidential relationship between Ms. Hockley, LMFT, CATC and said minor. Although the Representative(s) can expect to be kept up to date as to Client’s progress in therapy, he/she will typically not be privy to detailed discussions between

Therapist and Client. However, Representative can expect to be informed in the event of any serious concerns Therapist might have regarding the safety or well-being of Client, including suicidality. _____

CLIENT LITIGATION

Ms. Hockley, LMFT, CATC will not voluntarily participate in any litigation, or custody dispute in which the client or representative and another individual, or entity, are parties. There is a strict policy of not communicating with a client's attorney and Ms. Hockley, LMFT, CATC will generally not write or sign letters, reports, declarations, or affidavits to be used in in regard to a client's legal matter. Your therapist will generally not provide records or testimony unless compelled to do so. Should Ms. Hockley, LMFT, CATC be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving the client, the client or representative agrees to reimburse her for any time spent for preparation, travel, or other time in which she has made herself available for such an appearance at usual and customary hourly rate of \$125.00 for individuals, \$155.00 for couples, and \$175.00 for families. _____

PSYCHOTHERAPIST-CLIENT PRIVILEGE

The information disclosed by the client, as well as any records created, is subject to the psychotherapist-client privilege. The psychotherapist-client privilege results from the special relationship between a Therapist and Client in the eyes of the law. Typically, the client is the holder of the psychotherapist-client privilege. If Ms. Hockley, LMFT, CATC receives a subpoena for records, deposition testimony, or testimony in a court of law, she will assert the psychotherapist-client privilege on the Client's behalf until instructed, in writing, to do otherwise by the Client or Client's representative. You should be aware that you might be waiving the psychotherapist-client privilege if you make your mental or emotional state an issue in a legal proceeding. You should address any concerns you might have regarding the psychotherapist-client privilege with your legal counsel. _____

When a client is a minor child, the holder of the psychotherapist-client privilege is either the minor, a court appointed guardian, or minor's counsel. Parents typically do not have the authority to waive the psychotherapist-client privilege for their minor children, unless given such authority by a court of law. Representative is encouraged to discuss any concerns regarding the psychotherapist-client privilege with his/her attorney. _____

FEE AND FEE ARRANGEMENTS

Please Check the Appropriate Box Below

PRIVATE PAY

For individuals, the usual and customary fee is \$150.00 for the initial session and \$125.00 for regular sessions. For couples (any constellation of two), the usual and customary fee is \$175.00 for the initial session and \$155.00 for regular sessions. For families, the usual and customary fee is \$195.00 for the initial session and \$175.00 for regular sessions. Alcohol Treatment is \$225.00 a session. The initial session is an evaluation. All sessions are 50 minutes. Sessions lasting longer than 50 minutes are charged for the additional time on a pro-rated basis. The agreed upon fee between Therapist and Client is \$_____. Ms. Hockley, LMFT, CATC reserves the right to periodically adjust the fee. You will be notified of any fee adjustment in advance.

From time-to-time, there may be telephone contact with between Ms. Hockley and you for purposes other than scheduling sessions. The client is responsible for payment of the agreed upon fee for any telephone calls longer than ten minutes which will be the same as a pro-rated session fee. In addition, from time-to-time, Ms. Hockley, LMFT, CATC may engage in telephone contact with third parties at your request and with advance written authorization. You are responsible for payment of the agreed upon fee (on a pro-rated basis) for any telephone calls longer than ten minutes.

OR

INSURANCE

The client is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payors. Client is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payors, or by agreement with Therapist.

Therapist is a contracted provider with the following companies: **Aetna, Anthem Blue Cross, Beacon Health, Blue Shield, Magellan, Military One Source, and Multiplan** and has agreed to a specified fee. If the client intends to use benefits of his/her health insurance policy, he/she agrees to inform Therapist in advance.

FOR ALL CLIENTS

Clients are expected to pay for sessions or their portion of copay, coinsurance or deductible at the time services are rendered. Denise J. Hockley, LMFT, CATC accepts cash, checks, and major credit cards, including Visa, MasterCard and Discover as well as debit cards, however checks or cash are preferred.

There is a \$20.00 fee for any returned check. _____

CANCELLATION POLICY

You are responsible for payment of the agreed upon fee of any missed session(s). This includes any session(s) for which you failed to give Ms. Hockley at least 24 hours' notice of cancellation. This fee will customarily not be paid by an insurance company and Ms. Hockley cannot fill an appointment without required notice. This no-show or cancellation fee is \$50.00. The only exception to the fee is Military One Source. Cancellation notice should be left on Therapist's voice mail at 760-822-7729.

THERAPIST AVAILABILITY

Ms. Hockley, LMFT, CATC's office is equipped with a confidential voice mail system that allows the client to leave a message at any time. The therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. The Therapist is unable to provide 24-hour crisis service. **In the event that you are feeling unsafe or require immediate medical or psychiatric assistance, you should call 911, go to the nearest emergency room or telephone the Suicide & Crisis Hotline at 1800-999-9999 or Suicide Prevention Lifeline at 1-800-273-TALK.** _____

TERMINATION OF THERAPY

Your Therapist reserves the right to terminate therapy at 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, Client's needs are outside of Therapist's scope of competence or practice, or Client is not making adequate progress in therapy. You have the right to terminate therapy at your discretion. Upon either party's decision to terminate therapy, Ms. Hockley, LMFT, CATC will generally recommend that you 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. Ms. Hockley will also attempt to ensure a smooth transition to another therapist by offering referrals to you. _____

RECEIPT OF PRIVACY PRACTICES (HIPAA) FORM

Please initial if you have received a copy of the Health Insurance Portability and Accountability Act Form. It is always available on my website www.denisehockley.com under the forms section. _____

ACKNOWLEDGEMENT

By signing below, you acknowledge that you have reviewed and fully understand the terms and conditions of this Agreement. You have discussed such terms and conditions with the Therapist, and have had any questions answered to your satisfaction. You agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with Denise J. Hockley, LMFT, CATC. Moreover, you, as the Client or Representative agree to hold the Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Client (please print)

Signature of Client (or authorized representative)

Date

Client #2 (please print)

Signature of Client #2 (or authorized representative)

Date

Client Name (Please Print)

Signature of Client (if Client is 12 or older)

Date

I understand that I am financially responsible to the Therapist for all charges.

Name of Responsible Party (Please print first and then sign)

Signature of Therapist

Date