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LICENSED MARRIAGE
& FAMILY THERAPIST

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INFORMED CONSENT CONTRACT

WELCOME TO MY PRACTICE!

This document contains important information about my professional and business policies and how they may affect you. Please read them carefully and make a note about any questions you may have so that we can discuss them at the first session. Once you sign this agreement it becomes a binding agreement between us and also signifies your consent for us to begin therapy.

Our therapeutic relationship is entirely voluntary. Therapy is a process during which you and I will discuss a variety of issues, events, experiences and memories for the purpose of creating positive change. It provides an opportunity to better and more deeply understand yourself, as well as, any concerns you may be experiencing. Progress may vary depending upon both the presenting problem and your motivation.

Participating in therapy may result in a number of benefits to you, including, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in school, work, and family settings, increased capacity for intimacy and increased self-confidence. This includes honesty, and a willingness to change feelings, thoughts and behaviors. However, 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. There may be times when I will challenge your perceptions and assumptions and offer different perspectives. The issues presented by you may result in unintended consequences, including changes in personal relationships. It is important to note that decisions about these personal relationships are always up to you.

MY BACKGROUND AND QUALIFICATIONS

The name of my practice is Denise Hockley Counseling and I received my MS in Counseling Education from San Diego State University. I was licensed on 12-11-1992 by the Board of Behavioral Science Examiners. My License number is LMFT 30255 and I am a Licensed Marriage and Family Therapist. I was licensed by the state of Orgon on 1-18-2019 and my license # is T1513. I am a Clinical Member of the California Association of Marriage and Family Therapists in good standing.

POLICY REGARDING CONSENT FOR THE TREATMENT OF A MINOR CHILD

I generally require the consent of **both parents** prior to providing any services to a minor child. If any question exists regarding the authority a Representative to give consent for psychotherapy, I will require that the Parent(s) or Guardian(s) submit supporting legal documentation, such as a custody order, **prior** to the commencement of services.

FEES AND INSURANCE

The fee for service is $ 150.00 per individual initial session.
The fee for service is $ 125.00 per individual regular therapy session.
The fee for service is $ 175.00 per conjoint (marital/family) for an initial session.
The fee for service is $ 155.00 per conjoint (marital/family) for regular therapy sessions.
My private Outpatient Alcohol Treatment is $225.00 a session or $2700.00 for a 12-week series.
Other negotiated rate or copay $_____.

I reserve the right to periodically adjust the fee. You will be notified of any fee adjustment in advance. Fees, including insurance copayments, coinsurances and deductibles are payable at the time of the session. I accept credit cards but I prefer checks or cash. ***There is a $20.00 fee for any returned check***. All sessions are 50 minutes.

Please let me know if you wish to utilize health insurance to pay for services. We will discuss this prior to your first session. The specific amount of reimbursement and the amount of any co-payment 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 are also responsible for verifying and understanding the limits of your insurance coverage. I am happy to assist your efforts to seek insurance reimbursement. However, I am unable to guarantee whether your insurance will provide payment for the services provided to you. Please contact me with any further questions or concerns that you may have. Please inform me if you are unable to continue paying for your sessions. I will help you consider any options that you may have.

CANCELLATION AND RESCHEDULING

Sessions are typically scheduled to occur one time per week. I may suggest a different frequency of therapy depending on the nature and severity of your concerns. Consistent attendance greatly impacts the potential of a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify me at least 24 hours prior to the appointment. If you do not provide me with at least 24 hours' notice in advance, you will be responsible for payment for the missed or cancelled session. Please understand that your insurance company will not pay for missed or cancelled sessions. The no-show or late cancellation fee is **$55.00**. The credit card I have on file from you will be charged for any no-show or late cancellation fees.

CONFIDENTIALITY

During the course of treatment, all communications between you and me will be held in strict confidence unless you provide written permission to release such information. **Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, if you make a serious threat of violence towards a reasonably identifiable victim, or if you are dangerous to yourself or the person or property of another.**

NO SECRETS POLICY

If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all clients who participated in the treatment with me provide their written authorization to release such information. **However, it is important that you know that I utilize a "no-secrets" policy when conducting family or couples' therapy.** This means that if you participate in said therapy, I am permitted to use information obtained in an individual session that you may have had with me when working with other members of your family; unless it poses a risk.

MINORS AND CONFIDENTIALITY

Communications between myself and clients who are minors (under the age of 18) are confidential. However, as a parent or guardian who provides authorization for your child's treatment, you are often involved in the sessions. Therefore, using my professional judgement, I may discuss the treatment ***progress*** of your child with you. Please feel free to discuss any questions or concerns you have regarding this policy.

THERAPIST AVAILABILITY

My office is equipped with a confidential voice mail system that allows you to leave a message at any time. I 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. I am unable to provide 24-hour crisis service. **In the event of a medical or psychiatric emergency or an emergency involving a threat to 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 individuals who are in crisis:

Suicide & Crisis Hotline: 1-800-999-9999
Suicide Prevention Lifeline:1-800-273-TALK
Domestic Violence: 1-626-967-0658
Mental Health Help 24/7: 1-800-854-7771

THERAPIST COMMUNICATIONS

I may need to communicate with you by telephone or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform me if you do not wish to be contacted at a particular time or place, or by a particular means. Additionally, I will not respond to personal Social Media requests.

☐ My therapist may call me on my home phone. My home phone number is: _____
☐ My therapist may call me on my cell phone. My cell phone number is: _____
☐ My therapist may send a text to my cell phone. My cell phone number is: _____
☐ My therapist may call me at work. My work phone number is: _____
☐ My therapist may communicate with me by e-mail. My e-mail address is: _____
☐ My therapist may send a fax to me. My fax number is: _____
☐ My therapist may send mail to me at my home address.

Sensitive, clinical information is to be discussed over the phone or in-person as deemed appropriate by me. For appropriate email or text communication, I will respond to your email or text within 24 hours. Potential risks of using electronic communication may include but are not limited to; inadvertent sending of an email or text containing confidential information to the wrong recipient, theft or loss of the computer, laptop or mobile device, storing confidential information and interception by an unauthorized third party through an unsecured network. Email messages may contain viruses or other defects and it is your responsibility to ensure that it is virus-free. In addition, email or text communications may become part of the clinical record. You may be charged for the time it takes to spend reading and responding to emails and text messages.

RECORDS AND RECORD KEEPING

I take notes during session and will also produce other notes and records regarding your treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Such records are my sole property. I will not alter my normal record keeping process at your request. Should you request a copy of my records, such a request must be made in writing. I reserve the right, under California law, to provide you with a treatment summary in lieu of actual records.

CLIENT LITIGATION

I will not voluntarily participate in any litigation, or custody dispute in which you, your representative and another individual, or entity, are parties. I have a strict policy of not communicating with your attorney and I will generally not write or sign letters, reports, declarations, or affidavits to be used in in regard to your legal matter. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate of $125.00 for individuals or $155.00 for couples and families.

PSYCHOTHERAPIST-CLIENT PRIVILEGE

Typically, the client is the holder of the psychotherapist-client privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-client privilege on your behalf until instructed, in writing, to do otherwise by you or your representative.

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. You are encouraged to discuss any concerns regarding the psychotherapist-client privilege with your attorney.

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 at www.denisehockley.com. _____

TERMINATION OF THERAPY

The length of your treatment and the timing of the eventual termination of your treatment depends on the specifics of your treatment plan and your progress. We will collaborate on the termination of your therapy and discuss a plan as you approach the completion of your goals. You may discontinue therapy at any time and either of us may elect to initiate a discussion of treatment alternatives including referral, changing your treatment plan or termination.

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 me 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 me. Moreover, you, as the Client or Representative agree to hold me 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 Name (please print) Signature Date

_____

Client Name #2 (please print) Signature Date

_____ _____

Signature of Child (over the age of 12) Date

_____ _____

Signature of Therapist Date