**Mary Phalon, M.S., MFT**

**Licensed Marriage and Family Therapist**

**#50814**

**(925) 322-9305**

**Psychotherapy Consent Form**

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 Mary Phalon, 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 uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads 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 & 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 himself, others, or property of others.

•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.

1Second, 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.

**“No-Secrets” Policy**

If you participate in marital or family therapy, I 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 such information. **However, it is important that you know that I utilize a “no-secrets” policy when conducting marital/couples or family therapy.** This means that if you participate in marital/couples and/or family therapy, This therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family. Please feel free to ask me about my “no- secrets” policy and how it may apply to you.

**Fees and Insurance**

**Fees**: Fees are due and payable at the beginning of each therapy session by cash or check. A sliding scale rate is available for certain financial circumstances.

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 may be charged for services performed outside the therapy session (ie. school meetings, phone consultations, collaborating treatment, legal proceedings including travel time, etc.), which will be based on therapist’s standard 50 minute therapy hourly fee and prorated from this fee for every ten minutes beyond the standard 50 minute therapy hour

The fee for psychotherapy and consultation services will be $ 120 per 50-minute session. Either client or therapist may renegotiate this fee as circumstances warrant. Occasionally, the fee will increase due to inflation and increase in business costs, however clients will be given advanced notice of at least one month, and the opportunity to discuss such changes.

**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.

**Policies Regarding Appointments**

Individual, couples, and family therapy appointments are generally 50 minutes in length and are typically scheduled once per week at a time the therapist and client mutually agree upon. Sessions may be scheduled more often due to certain circumstances.

**Missed Appointments**: I have a 24 hours cancellation policy. If you cancel in less than 24 hours prior to a scheduled session, or do not attend your scheduled session, you will be charged the full fee for that session. Should a client be forced to cancel his or her session due to something outside their control (i.e. illness) every effort will be made to reschedule a make-up session so that client will not be charged. Make-up sessions cannot be scheduled for those sessions missed without prior notification. In those circumstances where a session is missed without prior notification, this therapist will recommend a rescheduling of that session to maintain consistency of therapy, however client will be charged for the previously missed session. In circumstances where a third party payer is financing treatment, the client will be billed for missed sessions at the therapist’s hourly rate and must seek reimbursement from third party payers on their own behalf. 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**

I maintain a confidential voicemail system and check my messages regularly during business hours, Monday through Friday, from 10:00 a.m. to 7:00 p.m. It is not always possible to return calls during the weekend; however I will call you back as soon as possible. **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 criminal 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 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.

**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. I 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 I determine that you are not benefiting from treatment, either of us 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.

By signing this form, you are acknowledging that you understand and consent to what you have read above, and we have discussed and clarified to your satisfaction any questions you may have.

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Client Name (Print) Signature Date

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Client Name (Print) Signature Date

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Print Name Signature of 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):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_