Disclosure Statement & Agreement for Service Contract

INTRODUCTION
This Agreement is intended to provide [Name of Patient] _____ with important information regarding our professional services and business practices. Please read it carefully and jot down any questions you might have so that you can discuss them with your therapist during your session. When you sign this document it will represent an agreement between us.

THERAPY SERVICES: We are a counseling center consisting of either Licensed Marriage Family Therapists, or Licensed Clinical Social Workers who provide therapeutic services to children, adolescents, adults, families and couples. If the problems you or your family experience are outside of our area of expertise, we will provide you with referrals to other professionals. You can obtain more detailed information regarding your Therapist's background during your intake appointment and/or on our website: www.buildingfoundationscounseling.com.

RISK AND BENEFITS OF THERAPY: Psychotherapy is not easily described in general statements. Experiences vary depending on the personalities of the Therapist and the Patient, and the particular problems that are brought forth. In order for therapy/counseling to be most successful, it requires a very active effort on your part. Without commitment to full participation (consistent attendance, application of therapeutic recommendation, and practicing of the techniques outside of session), symptoms may not improve. Therapy can have both benefits and risks. Anytime a person participates in mental health treatment, it is possible for symptoms to get worse before they get better. The process may involve discussing or discovering unpleasant aspects of life. You (or your child) may experience uncomfortable and possibly intense emotions. During this time, symptoms may vary. It is expected that with consistent attendance and participation, symptoms will improve. Therapy has also been shown to have many benefits, but Therapists are unable to guarantee that symptoms will improve as a result of counseling.

CONFIENTIALITY: Mental health records are created, securely maintained, and destroyed according to all federal, state, and internal requirements for the benefit of each Patient. Information obtained for treatment is confidential and may not be revealed without written permission of the Patient or Patient's Legal Representative, except where disclosure is required by law, such as under the following circumstances:

- If there is any suspicion of child abuse, molestation and/or neglect.
- If there is any suspicion of elderly or dependent adult abuse
- If there is evidence of imminent danger to you or another specified person
- If there is evidence of imminent self-harm (i.e., suicidal ideation or plan)
- If required by a court order

In order to protect your confidentiality, if your Therapist, or any of our Administration Staff, should see you outside of our office, please be aware we are unable to acknowledge you and we do not discuss therapeutic or scheduling issues outside of the office. Be advised that we utilize a "no secrets" policy when conducting family or marital/couples therapy. Also, if you are utilizing insurance to pay for your therapy, insurance companies require information regarding your dates of service, diagnosis, and occasionally treatment plan, and progress notes.

MINORS AND CONFIDENTIALITY: Communications between Therapists and Patients who are minors (under the age of 18 years) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment, and have the right to general information including how therapy is going. We use our professional judgment to determine the level of information provided to parents. Patients who are minors and their parents are urged to discuss any questions or concerns with their Therapist.

CANCELLED and MISSED APPOINTMENTS: Your appointment time is reserved specifically for you. It is important to arrive on time as the length of a typical session is 45-55 min and missed time caused by patient delay, will not be made up at the end of the session. Appointment cancellations require a 24-hour notice. If a 24-hour notification is not received the responsible party is liable for the session payment at the contracted rate, which ranges from $60-$120. The Cancellation notice should be left with office staff, or our voice mail at 916-988-5531. Excessive no-shows or cancellations may result in closure of your case.

PROFESSIONAL FEES and FINANCIAL RESPONSIBILITY: Patients (or Patient's Representative) are responsible for full payment of fees before services are rendered. (LT = Licensed Therapist and RI = Registered Intern)

- Initial intake assessment session pay a standard rate of $160 (LT) or $100 (RI)
- 45-55 minute sessions pay a standard rate of $120 (LT) or $80 (RI) for individuals, couples, or families.
- 90-minute EMDR sessions pay a standard rate of $180.
- 60-minute Group therapy/workshops sessions pay a standard rate of $40 per participant per session.
- 90-minute Group therapy/workshops sessions pay a standard rate of $45 per participant per session.

These fees may be adjusted by contract with insurance companies, employee assistance programs, contracts with other 3rd party payors, or by agreement with our Executive Director, Suzanne Mell, LMFT.

Insurance companies DO NOT cover telephone sessions. All phone consultations are based on availability and the Patient (or Patient's Representative) is responsible for the full fee. Phone consultations made at the request of the Patient (or Patient's Representative) will be charged at the above rates. Brief telephone calls with Therapists (under 5 minutes) are not charged. Patient (or Patient's Representative) will pay in full if insurance fails to pay within sixty (60) days from date of service.

In addition to regularly scheduled appointments, we charge the standard rate (i.e. $120 for Licensed Therapist or $80 Registered Intern) for other professional services you many need. Other services may include: written treatment summaries, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records, and time spent performing any other service you may request of us. Costs for such services will be made explicit prior to provision of services.

No shows will be billed at the fees listed above in "Cancelled and Missed Appointments". Full payment will be expected by the next date of service.

Your insurance company, Employee Assistance Program, Victim Witness or other 3rd party payors WILL NOT pay for no show or late cancelled sessions. Also be aware your insurance WILL NOT pay for a therapy session and a psychiatrist session conducted on the same day, so please check your calendar to avoid additional out of pocket expenses. Patient's (or Patient's Representative) signature acknowledges they will be fully responsible for payment of any late cancelled appointments/no shows for scheduled appointments.

Signature: _____ Date: _____

Patients are expected to pay for services at the time services are rendered. We accept cash, checks, Visa and Mastercard.

LEGAL PROCEEDINGS: The Patient (or Patient's Representative) agree that the services provided are of a "CLINICAL" nature and NOT of a forensic nature. Thus, the Patient (or Patient's Representative) willfully agrees that the Providers/Therapists will not be called by the Patient (or Patient's Representative) to testify or provide any information for any legal or forensic matters (including: Divorce, Custody, Medical Malpractice, Worker's Compensation, etc.)

If any therapist is required to attend a deposition, hearing, or other legal proceeding in the capacity of your current or past therapy, you will be billed for time including preparation, telephone time, and travel time, as well as, time spent at the legal proceeding.

A. PAYMENT:
   1. Scheduled deposition, hearing, court testimony, or other legal proceeding is billable at a half daily rate of $640 as therapist must clear their schedule for their required attendance. Half daily is four (4) hours or any portion thereof. Any hours beyond the initial 4 hours will be at $160 per hour.
   2. Mileage is charged at $0.55 per mile and fees for any copies made shall be charged.
   3. Fees shall be paid a minimum of seven (7) days in advance of the scheduled deposition, court testimony or records sent.

B. CANCELLATION:
   To avoid incurring the usual and customary charge, cancellation must be made at least five (5) working days in advance.

Signature: _____ Date: _____

The information disclosed by Patient, as well as any records created, is subject to the Psychotherapist-Patient privilege. The Psychotherapist-Patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. Typically, the Patient is the holder of the Psychotherapist-Patient privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, the Therapist will assert the Psychotherapist-Patient privilege on Patient's behalf until instructed, in writing, to do otherwise by Patient or Patient's representative. Patient should be aware that he/she might be waiving the Psychotherapist-Patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient should address any concerns he/she might have regarding the Psychotherapist-Patient privilege with his/her attorney.

ASSIGNMENT OF BENEFITS: The Patient (or Patient's Representative) authorizes Building Foundations Counseling Center, Inc. A Professional Family Counseling Corporation to submit claims on their behalf. The Patient (or Patient's Representative) authorizes the release of any medical or other information necessary to process claims or obtain authorization for services. The Patient (or Patient's Representative) agrees to assign insurance benefits and authorize payment of insurance benefits to the provider, Building Foundations Counseling Center, Inc. A Professional Family Counseling Corporation. The Patient (or Patient's Representative) agrees that you are responsible for full payment of all fees that are not covered by insurance including co-payments and deductibles. All co-payments and deductibles are ESTIMATED amounts. These amounts are not confirmed until our clinic received an "Explanation of Benefits (EOB)" at the time of billing.

Signature: _____ Date: _____

EMERGENCY PROCEDURES: If the Patient is experiencing a mental health emergency, immediately go to the nearest emergency room or call 911. Other options for emergency care include:

- **Sutter Center for Psychiatry (800) 801-3077**
- **Heritage Oaks Hospital (916) 489-3336**
- **Sacramento Mental Health Crisis Team (916) 732-3637**
- **Domestic Violence Help (916) 920-2952**

If there is an urgent need to speak with a Licensed Therapist after normal business hours, weekends or holidays, please call our main line (916) 988-5531 and follow the instructions that are provided for the On-Call Therapist to respond.

CLIENT RIGHTS: You have the right to ask about your Therapist's level of expertise and training. You have the right to inquire about other services that may be appropriate in meeting your needs. You have the right to review a summary of your records at any time, however, psychotherapy notes will not be released unless court ordered or in an emergency. If at any time, your Therapist and/or this Clinic, has determined that your Therapist and/or this Clinic is unable to meet your needs, or that you are not making progress as expected, your Therapist and/or this Clinic is obligated to discuss this with you and determine what changes or appropriate referrals need to be made. Consultation with other therapists, without using your identifying information, to determine what the best course of action is may be conducted depending on your therapeutic needs. You have the right to be informed that therapy never includes any sexual or business relationship or any other dual relationship that impairs a Therapist's objectivity or subjects you to be exploited or harmed in any way.

THERAPEUTIC RELATIONSHIP: It is important to understand what to expect from our professional relationship. In your best interest and following the ethical codes of our profession, your Therapist can only be your Therapist. A Therapist cannot have any other role in your life. A Therapist cannot be a close friend or socialize with any of their Patients. Your Therapist is unable to celebrate holidays or exchange any gifts.

GRIEVANCES: Developing a partnership with a Therapist relies on an open line of communication. If at any time the Patient (or Patient's Representative) are not satisfied with the services the Patient is receiving, we encourage the Patient (or Patient's Representative) to share their concerns with Therapist. Your Therapist will also gladly provide you with references for other professionals. We want you (or your child) to benefit from the services provided. Please do not

hesitate to discuss your concerns or questions about the counseling process with your Therapist during your scheduled session. You have the right to discontinue treatment at any time.

Consent: By signing below, Patient (or Patient's Representative) acknowledges he/she: Has reviewed and fully understands the terms and conditions of this Agreement; it is in an understandable language; feels able to make an informed consent to treatment based on the information reviewed, and understands the limits of confidentiality; emergency procedures; financial responsibilities, and treatment information. In addition, Patient (or Patient's Representative) consent to allow the assigned Therapist the right to provide services, conduct assessments, make diagnoses and treatment plans deemed appropriate or necessary for your Patient's mental health treatment.

Patient Name (please print)	
Signature of Patient (if Patient is 12 or older)	Date
Patient's Representative and Relationship to Patient (please print)	
Signature of Representative	Date
Patient's Representative and Relationship to Patient (please print)	
Signature of Representative	Date