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OFFICE POLICY & CONFIDENTIALITY

WELCOME! Thank you for choosing to enter therapy. My goal is that your courage will be rewarded with positive change. This is an opportunity to acquaint you with information relevant to treatment, confidentially, and office policies. I will be happy to answer any questions you have regarding this form.

I. **Aims and Goals:** The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflict which may disrupt your ability to function effectively in your life. This is accomplished by identifying treatment goals, increasing personal awareness, and increasing personal responsibly to make changes necessary to attain your goals.

II. **Appointments:** Clients are generally seen weekly or every other week as determined by the client and therapist. You may discontinue treatment at any time, but please discuss any reasons with your therapist. In the event of an emergency, your therapist may be reached at **916-753-5176**, or you can go to the nearest emergency room for assistance. You may also call **911.**

III. **Confidentiality:** Issues discussed in therapy are important and are generally legally protected as both confidential and privileged. However, there are limits to the privilege of confidentiality. These situations include 1)Suspected child abuse, 2) elder or dependent adult abuse, 3) If your therapist believes that you intend to seriously harm an identifiable victim, 4) If the therapist believes that you intend to physically harm yourself, the person or property of another, or are unable to care for yourself, 5) If your therapist is ordered by court to release information as part of a legal involvement in company ligations, 6) When your insurance company or billing service is involved, e.g. in filing claims, insurance audits, care review, or appeals, 7) In natural disasters whereby protected records may become exposed, 8) When otherwise required by law.

IV. **Record keeping:** A clinical chart is maintained describing your condition and your treatment and progress in treatment, dates of and fees for session, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations outlined in the “Confidentiality” section on this page.

V. **Fees:** The fee for each session is $100.00. The fee for phone counseling or emergency sessions by phone will be billed in 15 minute increments, at $25.00 per 15 increment. If you are using an insurance coverage, you will be responsible for all co-payments.

VI. **Payments:** Payments are due at the end of each session unless other arrangements have been made. Your therapist will file your insurance claim, but you are responsible for deductibles, co-payments, and co-insurance. It is your responsibility to familiarize yourself with your insurance benefits.

VII. **Cancellations and Missed Appointments:** You will be billed for a no-show or a cancelation with less than 24 hours' notice. The fee for missed appointments without timely notification is $100.

VIII. **Complaints:** You have the right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, please inform me immediately and discuss the situation. If you do not to feel the situation has been resolved you may also inform your insurance carrier and file a complaint if you so choose.

IX. **Consent for Treatment:** By signing the "Client Information and Consent" page you are stating that you have read and understand this 2-page policy statement and you have had your questions answered to your satisfactions.

I look forward to working with you.

Shevonne

CLIENT INFORMATION AND CONSENT FORM

Client Name:_____ D.O.B._____/_____/_____

Social Security Number: _____-_____-_____

Address: _____ Phone: _____

City: _____ Zip: _____ Cell:

_____

Employer:_____Occupation:_____

Are you currently working with a Psychiatrist? _____

IF YES, what is the Psychiatrist's name? _____

Do you have any major health related issues? YES NO

IF YES, please explain: _____

Please list any medications you are taking: _____

Do you experience problems use of tobacco, alcohol, or illicit drugs? YES NO

Who should be contacted in case of emergency? _____Phone#:_____

PLEASE INITIAL THE FOLLOWING AND SIGN BELOW:

_____ I accept, understand, and agree to abide by the contents and terms of the "Office Policy Statement", and further, consent to participate, or have my child participate, in evaluation and or treatment. I understand that I may withdraw from treatment at any time.

_____ I authorize the release of any medical or other information necessary to process insurance claims. I also authorize payment of medical benefits to Shevonne Radich, MFT for services provided by Shevonne Radich, MFT.

_____ I understand that in the event that my insurance does not cover the cost of treatment, I will be held responsible for any monies owed to Shevonne Radich, MFT.

_____ I acknowledge that I have been made aware of and have access to Notice of Privacy Practices.

Signature:_____ Date:_____

Signature:_____ Date:_____