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As your therapist, I look forward to working with you and want to give you some important information about the services you will receive. This will provide a clear framework for our work together and will facilitate our working relationship. Please feel free to discuss any of this with me.
I am a licensed Marriage and Family Therapist, licensed by the Board of Behavioral Sciences. Therapy involves a partnership between therapist and client. As your therapist, I will contribute knowledge, skills and the willingness to do my best. The determination of success, however, will ultimately depend upon your commitment to your own personal growth and care.

CONFIDENTIALITY:
The therapeutic relationship is based on the ability to trust. I am legally prohibited from revealing to another that you are in therapy with me, nor can I reveal what you have said to me that in any way identifies you without your written permission. However, in the following instances, your right of confidentiality must be set aside as required by law or professional ethical guidelines. This is a basic standard of practice in any psychotherapy.

- A client is threatening suicide and has a plan of action. If I believe that harm to self is imminent, then I am ethically bound to do what I can to help you keep safe. This may involve notifying others who may be of help or the client might require hospitalization.
- A client has indicated intent to harm another person and the likelihood of carrying out this plan is plausible. I must warn whoever may be in danger, and I must notify the appropriate authorities.
- A child has been sexually or physically abused and the perpetrator is in a position to continue harming the child or other children. I must report the abuse to Child Protective Services.
- A child is being neglected and remains in a harmful situation. I must report the abuse to Child Protective Services.
- An elderly person or dependent adult is being abused, neglected or financially exploited. I must report to Adult Protective Services.
- If a court has ordered your treatment with me, or if I am served with a subpoena in the context of a legal preceding in which **you** raise your own psychological state as an issue, I am required to release information to the court, or may have to appear in court.

When the therapist is treating a minor there are times family members will be included in the treatment. The rules and guidelines for exchange of information should be mutually decided on and documented in the chart or treatment plan. The minor should be included in this process.

SESSIONS:
As is standard practice, the psychotherapy session lasts for 50 minutes.
CANCELLATION POLICY: You are financially responsible for appointments that are not cancelled within 24 hours.

TELEPHONE ACCESSIBILITY: I will return calls as soon as possible should you need to speak with me between sessions. I do not charge fees for telephone consultations that are less than 10 minutes. Consultations of greater length will be pro-rated based on your hourly fee. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest hospital emergency room and ask for the psychologist (psychiatrist on call).

FINANCIAL RESPONSIBILITY:
We will agree upon a fee at the outset of treatment. You should pay at the time of each visit. It is a good idea to have the check or payment method prepared so as not to use your therapy time. If you have insurance, your claim will be filed every five weeks or you will be provided with a statement. The insurance company should reimburse you directly. The reimbursement should not exceed the payment to the therapist. The client is responsible for all payments. My fees may change over the course of the treatment.
I understand the above responsibilities and agree to a fee of $200 per session in office and $300 per session off-site. Accepted forms of payment include Major Credit Cards, Cash or Check.

Client Initials_____

Please feel free to ask any questions or discuss any of this information with me. Your signature below indicates that you understand and agree to the above contract:

Client Signature_____ Date_____

Therapist Signature_____ Date_____