CONSENT FOR TREATMENT

Welcome! This document contains important information regarding my professional services. Please feel free to ask me questions about these services at any time.

Confidentiality: It is my goal to provide a safe and supportive environment for my clients as they participate in therapeutic services. Your privacy is respected by keeping sessions confidential. Information about you is generally held in confidence by law. My policy is never to release information outside of sessions without your consent. However, as your therapist I am compelled by law and/or ethics to release information in one or more of the following circumstances:

- Suspected abuse, past or present, of a child under 18
- Suspected abuse of elders or dependent adults
- Intention of serious and dangerous harm to self or others
- When you waive your confidentiality (Confidentiality is waived when using your insurance company because they require information for payment or reimbursement of a claim)
- When you voluntarily use your mental or emotional state in legal proceedings
- Following a court order

Additionally, if you have recently been under psychiatric and/or medical care, it may be necessary for me to consult with the treating provider for the purposes of diagnosis, treatment and continuity of care. This informed consent agreement includes your consent for me to consult with other health care professionals as needed. _____ (initial)

Couples Therapy and Confidentiality: The confidentiality exceptions listed above also apply to couples therapy. My policy is to not hold secrets between partners. If one tells a secret between sessions or during an individual session, the assumption is that you are discussing it in order to get help disclosing it to your partner.

Adolescents and Children: The confidentiality exceptions listed above also apply to child and adolescent therapy. Because a safe and supportive environment is imperative for all clients, sessions between minors and the therapist are confidential. Parents will be provided with general progress information only. Additional information may be provided if it is determined to be in the child's best interest.

Financial Terms: **Payment for service is due at the time service is rendered.** A completed credit card form is required. My standard fee is $150.00 per 45- minute session unless a modification has been arranged. The best results occur when appointments are regularly scheduled and consistently attended. The standard fee will charged on a prorated basis for report or letter writing plus a $50 administration fee, attending meetings, telephone conversations longer than five minutes, or time required to perform requested services. I accept full financial responsibility for this account. _____ (initial)

Returned Check Policy: There is an additional $35 fee for any check returned for non-sufficient funds.

Cancellations: Your appointment time has been reserved for you. If you need to change your scheduled appointment, please provide 24-hour notice by calling (760) 522-8785. Missing your appointment or failure to give 24- hour notice of a cancellation will result in a $75.00 fee. Please note that insurance companies do not pay for missed appointment fees. Your appointment will automatically be cancelled if you fail to arrive within 15 minutes of your scheduled appointment. A $100 missed appointment fee will be assessed.

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Litigation Limitations: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regards to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, law suits, etc.) neither you, your attorney, or anyone else acting on your behalf will call Heather Williams to testify in court or at any other proceedings, nor will a disclosure of the psychotherapy records be requested.

Insurance: It is recommended that you contact your insurance carrier to find out how much they pay for outpatient psychotherapy treatment. The copay amount will depend on your policy. Many medical health insurance policies do cover at least part of the cost of outpatient behavioral therapy. Keep in mind that if you are utilizing insurance funds, third parties may review your medical record to obtain information about diagnosis, treatment process and prognosis for the purpose of treatment authorization, quality care management and payment for services. As a courtesy service, depending on your particular insurance provider, your insurance may be billed. Payment is required at the time of service, You will be required to pay all fees not covered or denied by your insurance.

I am choosing not to utilize insurance. I understand my insurance will not be billed by my therapist and payment is due when services are rendered. _____ (initial)

I understand that payment is due when services are rendered and that a HICFA 1500 form will be given to me to file with my insurance company for reimbursement. _____ (initial)

I understand that my insurance will be billed. However, co-payment is required at the time of service. _____ (initial)

Contacting Therapist: My voicemail is confidential. Please leave a message with your number, even if you think I already have it. I will return calls within 24 hours but I usually cannot provide emergency treatment. If you cannot reach me and you need to speak to someone immediately, please call the San Diego 24-hour Crisis Hotline at 1-800-479-3339 or 911. If an emergency occurs during our work together (or in the future after termination) where Heather Williams becomes concerned about your personal safety, possibility of you injuring someone else, or about you receiving proper psychiatric care, steps will be taken within the limits of the law to insure that you receive the proper medical treatment. Your emergency contact may be notified.

Independent Contractor Status: Heather Williams is not an employee or agent of the office located at 2774 Jefferson Street, Carlsbad, CA 92008. She is not the property owner/manager of this establishment. Other providers in this office are not the consultants or the partners of Heather Williams, LMFT. However, due to the responsibility of providing an appropriate standard of care, Heather Williams may need to consult with other licensed colleagues. These colleagues are held to the same legal and ethical standards as mentioned in this consent.

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Contacting Client: There may be times I will need to contact you. To ensure that confidentiality is kept, please initial the mode of communication and contact numbers you prefer:

_____ (initial) Home phone _____

_____ (initial) Cell phone _____

_____ (initial) Work phone _____

_____ (initial) e-mail _____

_____ (initial) US mail-may have therapy logo _____

I have read, understand and agree with all of the terms and conditions stated above

Print Client Name _____

Client Signature _____ Date _____

Print Client Name _____

Client Signature _____ Date _____

Consent to

Treatment of a minor _____ Date _____

Relationship to minor _____

A separate consent form for the treatment of a minor is required if child's biological parents are divorced and share joint legal custody. Consent for treatment must then be provided by both parents. If one parent has full legal custody, court documentation must then be provided.