INFORMED CONSENT AND CLIENT-THERAPIST SERVICE AGREEMENT

Client Name:

THERAPY SERVICES: Welcome to Laurie Schoenberg, MFT solo practice. This document contains important information about my professional services and business polices. I provide individual, couple, family and group therapy for individuals seeking assistance in improving the quality of their life. I reserve the right to deny service to individuals whose concerns are beyond my scope of competence as well as to any individual that abuses or misuses services in any manner; e.g. non-compliance with treatment, frequent missed sessions, delinquent payment, etc. If I am unable to offer you services for your specified need, I will discuss other local treatment options and possible referrals with you.
Initials_____

RISKS/BENEFITS OF THERAPY: Therapy is an intensely personal process which can bring up unpleasant memories or emotions. There are no guarantees that therapy will work for you. Client can sometimes make improvements only to go backwards after a time. Progress can happen slowly. Therapy requires clients to be active participants and to be willing to work on things we discuss outside of sessions. However, there are many benefits to counseling. Therapy can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to live in the present and many other advantages.

Initials_____

COUNSELING PROCESS: I will respect you as an individual and I will convey this respect by maintaining appointments with you or by contacting you if a change in times is necessary. I will give you my complete attention during sessions. You have the right to ask questions, at any time, about what occurs during therapy, and to receive answers that satisfy you. I will negotiate the frequency of sessions, number of sessions, goals, according to your presenting needs and diagnosis. We will re-evaluate the frequency of your sessions as situations arise and/or as you move towards your goals. You have the right to end therapy at any time. If you feel that you are not making progress towards your goal, you may terminate the therapeutic relationship and a final phone call or session is requested to complete closure. I will provide you with a list of referrals for therapists in the community. You will be responsible for any outstanding payments for services received. I will obtain your informed consent in writing if you decide to use the options of video conferencing; audiotaping or videotaping. You have the right to refuse any such recordings at any time.

Initials_____

IN AN EMERGENCY: Please leave a message on my confidential voice mail and state it is urgent that you reach me. In the event of a medical emergency or an emergency involving a threat to your safety or safety of others, please call 911 to request emergency assistance. You can also call the Riverside County Crisis & Suicide Helpline: (951)686-4357. I do not leave my phone on 24 hours. I typically turn off my phone at 8 pm and turn back on by 8 am Monday through Friday. Weekends are the same but I am checking messages less frequently. I will do my best to respond to emergency situations.
Initials_____

CONFIDENTIALITY: I recognize that confidentiality is essential to the client-therapist relationship. In order for therapy to work, you must feel safe about sharing your personal information. I will maintain your confidential information ethically and legally and I will only release confidential information with your expressed written consent (including minors). Exceptions in certain situations include, but are not limited to: when your records are subpoenaed for legal reason; when reporting is required or allowed by law (example: suspected child/elder abuse or neglect; minors sending sexting; extreme danger to self, or danger to others); when you sign a release, and other exceptions outlined in my *Notice of Privacy Practices.*
The following information is not a legal exception to your confidentiality, however, it is a policy you should be aware of if you are in *couples therapy*: If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. *Do not divulge anything in the individual sessions that you wish to kept separate from your partner during couple's sessions*. I will remind you of this policy before beginning each individual session.

Initials_____

RECORD KEEPING: I will keep records of your sessions and a treatment plan which includes goals for your therapy. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality section. Should you wish to have records released, you will be required to sign a release of information which specifies what information is to be released and to whom. Records will be kept 10 years but may be kept longer. Records will be kept either electronically on a USB flash drive or in a paper file and stored in a locked cabinet.

Initials_____

EMAIL AND TEXTING: Although both email and texting have become a major means of communication between individuals; these methods have significant limitations. Please note the following guidelines for use of email and texting as a form of communication between us:

- I cannot provide personal therapy solely through email or texting. I may offer limited support, but please be aware that email and texting communication is not a substitute for interpersonal therapy.
- Every effort will be made to keep email, text and voice mail information confidential. Please be aware that any system can be target of hacking and therefore vulnerable putting confidential correspondence at risk. Therefore emails, texts and voice mail will only be used for brief, time sensitive information exchange.
- For confidentiality purposes I do not store contact information in my electronic devices. Please be sure to identify your full name in your email and/or texts.
- **Email address:_____**

Initial_____

SOCIAL MEDIA It is unethical for a Therapist to accept "friends" request or contact requests from current or former clients on social networking sites. This policy is strictly out of concern for your confidentiality and my

professional privacy. Social Media connections may be considered a blurring of the boundaries of the therapy relationship.

Initials_____

FEES: Sessions are 45 minutes for individual sessions and 50 minutes for family or couple sessions. For those clients *without insurance…*the fee is $100.00 (except for the first session, which is $120.00. These session fees are payable at the time of service. When I am directly billing your insurance, your copayment and/or deductible is due and payable at each session. As a small business provider, it is not possible to carry account balances. Adhering to prompt session payment is required and greatly appreciated. The maximum flexibility in regards to owed payments is 2 sessions. If at any time the current fee schedule is not consistent with the available financial resources, I will work with you to find referrals for lower cost Therapy options. In the event that outstanding payments have not been made and are 60 days in arears, the owed balance may be referred to collections unless arrangements have been made prior to the 60 day mark. In the event a check is returned from the bank, the Client will be responsible for any service fees plus the amount of the original check.
Initials_____

At this time, the accepted forms of payments are checks, cash credit or debit cards.

Initials_____

CANCELLATIONS: Appointments are a commitment of time, meaning that the time is allocated to you and unavailable for other clients**. Missed sessions or those cancelled without 24-hour notice will be charged the full amount of insurance reimbursement (not just a copayment) unless Therapist is able to find another client to take the cancelled session.** Please Note: Insurance plans will not pay for missed or late-cancelled sessions. Those clients without insurance will pay their full out-of-pocket fee.
In addition, you are responsible for arriving to your session on time; if you are late, your appointment will still need to end on time.

Initials_____

INSURANCE PANELS: If I am a Provider with your insurance plan, I will submit claims directly to your insurance. Each session you are responsible to pay any portion of the fees not covered by your plan (deductibles/copays). I will give you an invoice at the end of each session regarding the amount due. If your form of payment will be by personal check; it would be helpful if you could have the check made out prior to coming to the session so your time in session can be used for the therapeutic process. If you will be paying with cash, please be aware I do not carry change. I will make every attempt to submit your claim to your insurance company for the payment due. However, there are times when payment is denied or withheld for administrative issues or mistakes within the insurance company's systems. After 2 attempts at collection, you will be responsible for the full payment and take over the primary role of collection directly through your insurance.

Please sign the following two statements, if using your insurance plan or Employee Assistance Program:

"I authorize the release of any information necessary (including treatment summaries and diagnosis) necessary to process insurance plan or EAP to process claims, determine medical necessity, or to request additional sessions."

(Full Signature here):_____Date:_____

"I authorize payment of insurance claim reimbursement to: Laurie Schoenberg, MFT for services provided."

(Full Signature here):_____Date:_____

It is critical that clients divulge the existence of duel insurance coverage at the time of the intake session. Insurance companies will withhold or demand a reimbursement for a prior claim paid to Therapist if they discover Client has a second insurance. Sometimes this happens a year after a claim has been paid. If this occurs because a second insurance was not divulged; client will be responsible for paying any outstanding fees their insurance company claims is owed due to the secondary insurance.
If there are two insurance panels, I will bill only to the primary panel. I will give you a "SUPER BILL" for you to submit to your second insurance. **Any payments due covered by the secondary insurance will be required to be paid at the time of service by client to Therapist.**

Initials_____

COURT MANDATED THERAPY, CHILD CUSTODY/REUNIFICATION THERAPY, or any THERAPY LINKED to the LEGAL SYSTEM including MEDICAL/DISABLED LEGAL MATTERS: I do not accept these cases because they are **outside my scope of competence**. I do not write letters, submit reports or sign declarations for attorneys; nor make recommendations to the court. If legal concerns shift during the course of therapy; I will attempt to assist you in obtaining referrals to therapists where this type of therapy is in their scope of competence.

Initials_____

DISCLAIMERS: It is understood than any agreements made are between you and Laurie Schoenberg, MFT only. I cannot be responsible for the care provided by professionals or groups that I refer you to. It is up to you to thoroughly check out any referrals and decide if the services offered will meet your individual needs.

Initials_____

Board of Behavioral Sciences: Receives and Responds to complaints regarding services provided within the scope of practice of Marriage and Family Therapists. If for any reason you have a complaint you may contact the board on-line at: **www.bbs.ca.gov,** or by calling: **(916) 574-7830.**

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Client's Full Signature **Date**

PRIVACY POLICY: I am acknowledging receipt of my *Notices of Privacy Practices.* My *Notice* provides information about how I may use and disclose your private health information. I encourage you to read it carefully. My *Notice* is subject to change. If I change my *Notice,* I will give you a revised *Notice*. If you have left treatment, you may obtain the revised notice from me at my office address. If you have any questions about the *Notice* or any of the above, please feel free to ask.

Initial_____

I have read signed and/or initialed the Informed Consent and Client-Therapist Service Agreement in its entirety:

_____	_____	_____
Signature of Client	**Print Name**	**Date**

_____	_____	_____
Signature of Client's Partner (Couples Therapy Only)	**Print Name**	**Date**