Informed Consent & Agreement For Services
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Welcome to my practice. This Informed Consent & Agreement for Services contains important information about my professional services and policies. Please read the entire document carefully and ask any questions you have regarding its contents.

Information About Me

Prior to beginning treatment, I will discuss my professional background and provide you with information regarding my experience, education, special interests, and professional orientation.

I am a Licensed Marriage and Family Therapist (LMFT 102717)

About the Therapy Process

It is my intention to provide services that will assist you in reaching your goals. We are partners in the therapeutic process. As partners, we will work together to develop a plan for your treatment. Based on the information you provide to me and the specifics of your situation, I will offer feedback and recommendations regarding your treatment and progress.

As a new client, it is best practices to meet for three (3) sessions. After the third session we will decide if the therapeutic alignment between us is most beneficial for your care. If either one of us agrees that we are not in alignment, we will terminate this relationship and, upon request, referrals will be provided.

Over the course of therapy, I will attempt to evaluate whether the therapy provided is beneficial to you. While I hope our work together will be effective, the amount and length of treatment varies from patient to patient. I am unable to predict how long you will be in therapy or guarantee a specific outcome or result of our work together.

Therapy sessions are approximately 50 minutes each. Typically, sessions are scheduled once per week. Consistent attendance contributes greatly to a successful outcome.

Fees and Insurance

The fee for service is $140.00 per individual therapy session.
The fee for service is $_____per conjoint (marital /family).
The fee for service is $_____per group therapy session.

Fees are payable at the time that services are rendered. I accept payment in the form of cash, check, credit card, or electronic payment. It is my goal to maximize your session time. Therefore, if you are paying for a session via a debit card, credit card, or electronic payment please let me know ahead of time so I can collect and/or provide the necessary information.

You are ultimately responsible for payment for services received. I will notify you in the event of any changes to fees or when other charges are to be applied.

I do **not** accept insurance. I am a private pay/cash pay business only. However, I am happy to provide you with a superbill (a.k.a. a receipt for services) which you can submit to your insurance for potential reimbursement. Depending on the terms of your health coverage, your plan may or may not reimburse for out-of-network services.

My Medicare Provider Status

Please be aware that**:**
I am an Opted-Out provider. This means I am not contracted with Medicare. Medicare will not reimburse you for the cost of my services. If you are a Medicare beneficiary, please note that we will continue with a private contract for therapy services in order for me to treat you.

Your Medicare Coverage Status

Are you a Medicare beneficiary?

☐ Yes ☐ No

Since I am an Opted Out Provider:

- I will **not** submit claims to Medicare for any services provided to Medicare beneficiaries during the opt-out period.
- I will not allow anyone to act on your behalf to submit claims to Medicare.
- This document confirms that you are responsible for the full cost of your care and that Medicare will not reimburse you.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur once per week. I may suggest a different amount or frequency of therapy depending on the nature and severity of your concerns. Your consistent attendance can greatly contribute to a successful therapy outcome.

To cancel or reschedule an appointment, please notify me at least **24 hours** in advance of your appointment. If you do not provide me with at least **24 hours**' notice of cancellation, I will charge you $140 for the missed session. If you are using insurance, please be aware that your insurance company will not pay for missed or cancelled sessions. Accordingly, you will be responsible for covering the cost of missed sessions and sessions cancelled within **24 hours** of the scheduled session.

Client Rights

As a consumer of psychotherapy, you have certain rights you should be aware of. The following list is not exhaustive and is only meant to provide you with an outline of what your rights are.

1. You have a right not to receive psychotherapy, and to end therapy at any time, without notice or further obligation, should you so deem.
2. You have a right to ask questions with regards to therapeutic techniques or procedure being used, and you have the right not to consent to any technique or procedure for any reason.
3. You have a right to ask questions concerning the length of therapy and termination of therapy. However, a therapist is not able to guarantee or promise a specific length of therapy necessary due to the personal nature of psychotherapy, as individual needs, desires, and growth greatly vary.
4. You have a right to a reasonable financial arrangement for services rendered. It is expected that the agreed upon fee will be paid at the conclusion of each session unless prior arrangements have been made. Prior to your initial session, you will be advised of the hourly rate (50 minutes) charged per session. I am also providing you with a Good Faith Estimate as to the costs of psychotherapy services.

5. Telehealth communications include, but are not limited to, communications through the phone, e-mail, the internet, voicemails and texts. I understand my therapist's written electronic communications may not be encrypted. I understand there are risks of communicating with my therapist through unencrypted electronic communication devices (text or e-mail) including an increased risk of unauthorized access to confidential information, and possibly a breached security of transmissions. Threats to confidentiality include but are not limited to the following: 1) the transmission may be intercepted; 2) the transmission may be sent to the wrong recipient; and 3) the e-mail or text message may be accessed by an unauthorized person. I also understand e-mail and text are not appropriate forms of communication in a crisis, and brief abridged messages via email or text can be misconstrued and affect the therapeutic relationship. If my therapist does not think communications via phone, e-mail or texting are appropriate and/or beneficial for me, my therapist may choose to provide me with therapeutic services exclusively through a face-to-face format.
6. If your therapist counsels your spouse, you must agree not to subpoena the therapist or records relative to counseling.
7. It is strongly recommended that you have a thorough physical examination from a medical practitioner on an annual basis. It is strongly recommended that you have a thorough medical examination within the first month of therapy to medically address any potential complaints or concerns, which may have an impact in your therapy.
8. **Confidentiality**: You have a right to expect that your therapist will keep the facts of your therapy private and confidential. This includes not disclosing, to anyone, the fact that you are in therapy, family information, discussions, appointments, or any information that is brought up in your therapy, except under those circumstances where the therapist is mandated by law to report, or where permitted by law, unless the therapist has received your expressed written consent
9. Your therapist is permitted by law to disclose confidential information for a valid purpose, such as (1) if your therapist is a trainee or intern, they are required to report your progress and any potential concerns or problems to their supervisor; (2) to obtain appropriate professional consultation(s); (3) to obtain payment for services that may require releasing limited information necessary to achieve proper payment (i.e. insurance, court referred/ordered); (4) court ordered subpoena. Except in the above-mentioned criteria, your therapist will not release any information outside of session (i.e. letters to attorneys, courts, or mediators, etc.).
10. Your therapist is the treating therapist and does not provide services in contemplation of legal proceedings. If your therapist responds to any subpoena on your behalf whether through document preparation, deposition, personal appearance or any other requested legal proceeding, you will be billed at the therapist's standard hourly fee.
11. If you initiate a lawsuit against someone, his or her right to the best defense supersedes your right to confidentiality. His or her attorney has the right to subpoena your records, take your therapist's deposition, have your therapist appear in court, or all of the preceding.
12. If you are in therapy or being tested by a court of law, test results and/or treatment may be disclosed to the court.
13. If a court of law issues a legitimate subpoena, your therapist must provide the information specifically requested. In releasing such information, the minimum amount of information necessary to accomplish the purpose of the communication will be followed.
14. Your therapist is a mandated reporter. As such the State of California requires:

a. Evidence which suspects child or elder abuse by neglect, assault and battery, or sexual abuse, sexual assault, or sexual exploitation may be disclosed to the state. Please note that the legal definition of "child abuse" generally includes instances of "sexting" in which a person of any age captures, records, sends, receives, or possesses an image or video depicting a minor engaged in sexual or otherwise obscene conduct.

b. If there is cause or a reasonable belief that you may pose a serious, imminent or great likelihood of danger or an act of violence to another or another's property, your therapist has an obligation and responsibility to exercise reasonable care to protect the intended victim(s) from that danger, and must warn the intended victim(s) by taking reasonable steps necessary under such circumstances, and informing the appropriate law enforcement agency. However, your therapist's obligation requires that they not disclose a confidence unless such disclosure is

necessary to avert danger to others, and even then, that they do so discreetly and in a fashion that would preserve the privacy of the client to the fullest extent compatible with the prevention of the threatened danger.

15. If your therapist has a reasonable belief that you may potentially attempt suicide, your therapist may disclose this information to others (i.e. family member(s), friends) if such disclosure is deemed necessary in attempting to prevent the threatened danger, then your therapist will take reasonable steps to prevent such an attempt. In addition to seeking the assistance of appropriate family and friends, your therapist may inform or consult with an emergency medical team, local police, or law enforcement agency.

Confidentiality and Treatment of Minors

If a minor's parent(s) or guardian(s) give consent for me to treat the minor, I typically provide the parent(s) or guardian(s) with general updates about the minor's treatment. These updates may include the minor's diagnosis, treatment plan, progress in therapy, session attendance, or similar information. However, I generally do not share specific details about the minor's treatment or what the minor has shared with me during sessions unless: 1) the minor gives me permission to disclose such information and I believe the disclosure would be clinically appropriate; or 2) the minor is experiencing a crisis or other emergency circumstance that would authorize me to break confidentiality.

If the minor consents to their own treatment, the law generally prohibits me from communicating with their parent(s) or guardian(s) without written authorization from the minor unless the minor is experiencing a crisis or other emergency circumstance that would authorize me to break confidentiality.

Please feel free to reach out to me if you have questions about these policies or if you would like to discuss them further.

Confidentiality and Couples / Family Therapy

If you are participating in couples or family therapy, please be aware that, in most circumstances, the law prohibits me from disclosing confidential information and records regarding the unit of treatment's services unless *all* identified patients provide written authorization to release the information.

No Secrets Policy

I would also like for my couples and family therapy patients to be aware that I utilize a "no-secrets" policy. This means, when I determine it is clinically appropriate or necessary to do so, I am able to disclose information I obtain from one member of the couple, or a participating member of the family therapy unit, (i.e. the "treatment unit") with the other member(s) of the treatment unit. This policy also applies to information a member of the treatment unit shares with me outside of couples / family sessions (e.g. via email, text, etc.) and information I obtain during individual session(s) with a member of the treatment unit (should we agree to hold individual sessions in furtherance of your couples / treatment goals). I find that this policy facilitates effective communication with and between my couples and family therapy patients. It also helps me to avoid potential problems which may arise when a therapist is perceived to be "keeping secrets" from other members of the treatment unit.

My Communication With You

From time to time, I may need to communicate with you outside of our sessions together to discuss scheduling, payment, or other issues related to your treatment. To respect your privacy, it is important for me to understand your communication preferences. Please indicate your openness to receive communication from me via the following methods:

Phone

My Home Phone Number is _____

☐ I authorize my therapist to call me at this number

☐ I authorize my therapist to leave messages for me at this number

My Cell Phone Number is _____

☐ I authorize my therapist to call me at this number

☐ I authorize my therapist to leave messages for me at this number

Additional Information About Unencrypted Text Messaging: I value your privacy and take appropriate steps to preserve the confidentiality of information shared between us. However, it is important to be aware that certain risks may still be present when communicating via unencrypted text, such as technological failures or unintended access by third parties.

☐ I understand the information above and authorize my therapist to communicate with me via unencrypted text using the cell phone number I provided.

Email

My Email Address is _____

Additional Information About Unencrypted Email: I value your privacy and take appropriate steps to preserve the confidentiality of information shared between us. However, it is important to be aware that certain risks may still be present when communicating via unencrypted email, such as technological failures or unintended access by third parties.

☐ I understand the information above and authorize my therapist to communicate with me via unencrypted email at the email address I provided.

Mail

My Home Address is _____

☐ I authorize my therapist to send necessary, treatment-related information to me at this address.

Additional Communication Information and Preferences

Please feel free to inform me if there are additional communication preferences you would like for me to be aware of, or if you do not wish to be contacted at a particular time, place, or by a particular means.

I will do my best to honor your communication preferences, but please be aware that in certain instances, such as emergency circumstances, I may need to reach you through other methods.

Emergency Contacts

It is critical for me to know who I can contact in the event that you are experiencing a medical or psychiatric crisis or other emergency circumstance. Please identify these individuals in the space provided below:

Emergency Contact 1

Name _____

Relationship to Patient _____

Home Phone Number _____

Cell Phone Number _____

Emergency Contact 2

Name _____

Relationship to Patient _____

Home Phone Number _____

Cell Phone Number _____

Your Communication With Me

My Contact Information

Outside of our sessions together, my preferred method of communication are as follows:

You may text or call me at 909-631-9916

I understand that you may need to reach me outside of normal business hours on occasion. However, I ask that you please respect my personal time and only call or text me if it is truly urgent. If you have a question or concern that can wait until the next business day, please do so. This mode of communication is not intended to provide any therapy services but should only be used to advise of urgent matters or appointment related matters.

You may email sandraantonellilmft@outlook.com

Nonurgent Communications

If you would like to contact me in-between sessions to discuss a nonurgent issue, such as scheduling or payment, please do so during my normal business hours of Monday – Thursday 9:00 a.m. to 5:00 p.m.

Please understand that I may be in session with other patients or addressing other matters when you attempt to reach me. If you send or leave me a message, I will respond as soon as I am available, but please be aware that I may respond to your communication up to 48 hours after receiving your message.

Urgent / Emergency Communications

If you are ever experiencing a medical or psychiatric emergency or if you are facing an emergency involving a threat to your safety or the safety of someone else, please call 911 to request emergency assistance. In the event of a mental health crisis, you may also call the 988 Suicide & Crisis Lifeline by dialing “988.”

Therapy Across State Lines

Unfortunately, I may not be able to treat you while you are physically outside of the state of California. My ability to do so depends on various factors, such as the laws of the jurisdiction you will be traveling to. If you know you will be traveling outside of the state, please provide me with as much advance notice as possible so I may have

enough time to determine whether I will be able to provide treatment to you during that time.

If you are paying for therapy via health insurance, Medi-Cal, or another third-party payer, using the provided superbill, advance notice of your travel plans will also allow us to discuss whether your plan covers therapy across state lines and/or alternative payment options, if necessary and appropriate. Please be aware that not all plans cover therapy across state lines.

If I am unable to treat you while you are outside of California, we can discuss alternative care options and strategies as well as what you should do in the event of an emergency.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on your clinical needs, the specifics of your treatment plan, and the progress you make towards achieving your treatment goals. While I hope you will find our time together beneficial and meaningful, I cannot guarantee the specific outcome(s) or result(s) your treatment will yield.

You may discontinue therapy at any time. If one of us determines you are not benefiting from treatment, we can discuss treatment alternatives. These alternatives may include, among other possibilities, changes to your treatment plan, referrals to other therapists, and/or termination of treatment.

Questions About My Policies

Please let me know if you have any questions about my policies or if you would like to discuss them further.

Informed Consent

Your signature below indicates that you have read this agreement for services and disclosures carefully, understand its contents, and consent to receive treatment from me.

_____
Name

_____
Patient's Name (If You Are Not the Patient)

_____
Relationship to Patient (If Applicable)

_____
Signature

_____
Date