**Rebecca Picard, LMFT**

**Psychotherapist**

**45121 Ukiah Street, Suite C**

**Mendocino, CA 95460**

**707.357.8688**

**Agreement for Services/Informed Consent**

 **Introduction**.  This agreement is intended to provide \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (“the client” or “you”) with important information regarding the services of and therapy relationship with Rebecca Picard, M.A. (“therapist”), Licensed Marriage and Family Therapist #112212. The client is welcome to ask questions about Rebecca Picard’s background and orientation or about any aspect of this agreement at any time.

 **Risks and Benefits of Therapy.**You have taken a positive step in seeking therapy. Psychotherapy is a process that is likely to touch on many issues, events, experiences, sensations, memories, thoughts, beliefs, emotions and patterns for the purpose of creating positive change. Participating in therapy may result in benefits such as reduced stress and anxiety, decreased negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, increased self-confidence and self-compassion, freedom from limiting beliefs, freedom from reactivity and automatic bodily responses, increased awareness of triggers and limiting patterns, and expanded capacity to engage in life. There is, however, no guarantee that therapy will yield any of these benefits, and they are unlikely to occur unless the client engages fully in the process. Progress may be gradual.

Participating in therapy may also involve discomfort, including the surfacing of unpleasant or traumatic events, feelings and experiences. Clients may find that they feel worse before they feel better. There may be times when the therapist will challenge the client’s perceptions and assumptions. The issues presented by the client may result in unintended or unforeseen outcomes, including changes in personal relationships, although any and all decisions about the status of the client’s personal relationships remain the choice and responsibility of the client.

**Confidentiality.**The client’s identity and communications with the therapist are confidential except as described below. The therapist will maintain confidentiality unless disclosure is required or authorized by law or unless the client signs a written release identifying those to whom specifically described information may be disclosed. If a language interpreter is involved in the counseling process, the interpreter agrees to be bound by the same confidentiality as the therapist.

**Exceptions to Confidentiality.**As a mandated reporter, the therapist is required by law to report physical, sexual and neglectful child abuse, elder abuse, and dependent adult abuse if she has a reasonable suspicion that it is occurring or has occurred. In some cases, emotional abuse may also be reported. The therapist is also required to report necessary information to prevent harm if and when clients pose a threat of serious harm either to themselves or to the person or property of another. Should such disclosures be necessary, the therapist will disclose only that amount of information required to fulfill the purpose of the disclosure.

 If the therapist receives a court order requiring disclosure of client records, the therapist is legally required to comply, although she may consult with legal advisors through the California Association of Marriage and Family Therapists (CAMFT) to limit the information released. Occasionally, the therapist may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you (the client). In that context, information about you would be shared without using your name or other identifying information.

**Records.**The therapist will keep records relating to therapy sessions, goals and progress. Your records will not be shared except as described in the section above regarding exceptions to confidentiality. Should you want a portion of your records to be released to someone, you will be required to sign a Release of Information form. The therapist will store records regarding your sessions either through a HIPAA-compliant website or in a locked cabinet and will keep them for seven years. HIPAA – the Health Insurance Portability and Accountability Act -- is a federal law providing privacy protections and rights regarding the use and disclosure or your Protected Health Information (PHI). If you want to have your records released to you, you must make a written request to the therapist, who may choose to provide a summary.

**Litigation/Actions in Court.**  The therapist will not voluntarily participate in any court action in which the client and another party are involved.  Only if she is legally compelled to do so will she provide any records, information or testimony in such litigation.

**Appointments, Rescheduling and Cancellations.** Traditionally, psychotherapy appoints are 50 minutes in duration, once per week at an agreed time. However, depending upon your needs, the therapist and client may agree upon a different schedule or duration with designated start and end times. If you need to cancel or reschedule a therapy session, please provide at least 48 hours’ notice via telephone or text at 707.357.8688 as there is a possibility that another client may be able to use your scheduled time. Sessions missed without 48-hour notice of cancellation will be charged at the therapy hour rate unless the lack of 48-hour notice was the result of a genuine emergency. Please note that insurance companies will not provide reimbursement for missed therapy sessions. If you call to reschedule, I will make every effort to accommodate your needs.

**Communications Outside of In-Person Sessions.** Texting or emailing with the therapist should be limited to logistical issues such as scheduling. Clients may leave a confidential voicemail, understanding the limits of confidentiality when communications take place over technology. Clients may request the option of communicating messages through the HIPAA-compliant Simple Practice client portal that the therapist will offer to them.

**Telehealth Services.** Under some circumstances, it may be appropriate to conduct therapy sessions on the phone or through an internet-based video platform. The video platform requires the client to have access to the internet in a sufficiently private environment. There are risks associated with conducting therapy through the use of such technology, particularly if the client is in a particularly aroused or vulnerable state, and it may not be possible to achieve the same level of rapport and attunement without being together in person. The client must be willing to disclose his or her location at the time of the telehealth therapy session. The benefit of telehealth services is convenience, and in some circumstances is the only option. Fees for telehealth are the same as for in-person sessions. By signing here, client acknowledges her consent to receiving telehealth services, if offered by the therapist.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Professional Fees**. You, the client, are responsible for paying for services at the time of your session unless prior arrangements have been made. Payments may be made by cash, check or credit card. Credit card payments will be processed through a secure, HIPAA-compliant website.

**Payment through Health Insurance**. If you have made arrangements with the therapist prior to the outset of therapy for your therapy to be paid through Partnership Beacon Health Options MediCal or by another preauthorized referral to Beacon Health Options, she will bill them directly. Otherwise, you are responsible for paying all psychotherapy fees at the time of service. If you determine that your health insurance covers psychotherapy and/or mental health services, the therapist will, upon request, provide you with a receipt for services commonly referred to as a Superbill, and your insurance may reimburse you for part of the fee. If you plan to utilize insurance as part of your payment for therapy services, you are likely to need prior authorization from the insurance company to assure that they will reimburse you for psychotherapy fees. Please discuss with your insurance provider the extent of your coverage, co-pays, and deductibles so that you are fully informed about your monetary obligations prior to starting post-intake psychotherapy sessions.

**Fee Schedule for Private Pay**

Individual Therapy:

Initial Intake (phone or as part of initial session)

 30-45 minutes No Charge

Assessment (if indicated) 80-90 minutes $150.00

Individual therapy 50 minutes $100.00

Individual therapy 80 minutes $150.00

I offer a sliding fee to a limited number of clients, depending upon individual circumstances. In such cases, the exact fee will be worked out in advance.

**Therapist Availability**. The therapist does not provide 24-hour crisis service. If the client requires immediate medical, psychiatric or safety assistance, it is the client’s responsibility to call 911, go to the nearest emergency room or call the Coastal crisis line (855.838.0404). The therapist will generally return phone calls during the work week; if the therapist anticipates being unavailable for more than four days, she will provide a back-up referral.

**Termination of services.**  Either the client or the therapist may terminate the counseling relationship and/or suggest termination by giving reasonable notice to the other. It is expected that therapy will terminate when the client has made progress or has determined that no progress is being made after reasonable effort. Both therapist and client agree to participate in one or more termination sessions to provide an opportunity to reflect on their work together and to provide a smooth transition to the client’s next step. In appropriate cases, therapist will refer the client to another practitioner.

**Acknowledgment and Consent to Treatment.**  By signing below, the client acknowledges that he/she has reviewed and understands this agreement and consents to psychotherapy treatment under these terms.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interpreter’s signature (if any):

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Client’s printed name and physical address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Phone number: H:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May messages be left here? \_\_\_\_\_\_\_\_\_\_\_

W:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May messages be left here? \_\_\_\_\_\_\_\_\_\_\_

C:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May messages be left here? \_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_