

Sue Ann Edwards, M.A., M.F.T., R.P.T.S.

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Contract for Psychotherapeutic Services Consent for Treatment Form

Welcome to my therapy practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions so that we can discuss them. When you sign this document, it will represent an agreement between us.

THE THERAPY PROCESS

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort by the client. In order for the therapy to be most successful, the client will have to work on things we talk about during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of life, uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness may be experienced. On the other hand, psychotherapy has also been shown to have benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. When working with children, behavioral symptoms often increase before positive changes occur.

Our first few sessions will involve an assessment of client needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise.

CONFIDENTIALITY

According to professional ethics and California law, all communications between a client and a therapist is confidential and privileged. I cannot release or share this information without the written permission of the client. For child clients, parents can provide written authorization to share information with other professionals but cannot waive a child's privilege in legal proceedings.

There are exceptions to client confidentiality. If abuse of a minor child or an elderly person is suspected or may be occurring, a therapist is required to notify the local law enforcement agency and county protective agency. Therapists are also required by law to warn an individual and the police, of seriously threatened harm to that individual if such is disclosed during the course of therapy. Confidentiality may also be broken if information is revealed that indicates that a client may cause harm to him/herself. Also, should an account become past due such that the collection process is initiated, then a patient's right to privacy is curtailed to the extent necessary for collection.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss them.

PROFESSIONAL FEES

The fee for a standard therapeutic session of 45-50 minutes is \$250. Extended sessions (those longer than 50 minutes) are billed at the hourly rate of \$300.

Telephone conversations that are brief and are used to transmit logistical information, schedule, appointments, etc., are not subject to charges. More lengthy conversations, wherein advice is sought or therapeutic issues are discussed, are billed at a percentage of the hourly fee, based on the amount of time needed, with a minimum increment of 15 minutes at \$75. Other services like telephone consultations with other treating professionals (e.g. teachers, physicians, other therapists), email communications to be read, consultations to schools, meetings, reading or writing reports, etc. are not included in the above fees and will be billed separately at \$300 per hour, with additional cost for travel.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, even if I am called to testify by another party. Involvement in legal issues are subject to a separate fee schedule due to the difficult and disruptive nature of court proceedings.

Payment is expected at the time of service. If there are services for which you are not present, (i.e. phone consultation, collateral contact with other professionals, report writing, etc.) you will be billed at the end of the month and are expected to pay the invoice upon receipt. A \$35 late fee will be added for all accounts not current past 30 days. A \$35 fee will be charged on returned checks; payment in full, including this charge, is expected within 5 days of notification or the patient will be charged three times the original amount of the check, as allowed by law.

OFFICE POLICIES

Payment for Services: You are expected to pay for services at the time they are rendered. For your convenience, we accept payment by way of cash, check, VISA, or MASTERCARD.

Billing Questions: All questions regarding billing should be directed to *Linda Saucier at Griebel Billing Services at (619) 224-6343*; her fax number is (619) 222-0788. Please retain copies of your monthly statements as your personal financial records. Requests for additional statements or summaries will require an additional accounting fee.

Cancellation: An appointment reserves time specifically for you. Missed appointments are costly to the therapist and deny other individual the opportunity to use that time. Therefore, unless a true emergency exists, a minimum of 24-hours notice is required for rescheduling or cancellation of an appointment. The full fee will be charged for sessions missed without such notification. Insurance companies do not reimburse missed appointments.

Divorced Parents: For parents who are divorced or separated, please understand that our billing office will not provide multiple accounts for one client nor attempt to implement divorce payment agreements. We create one account for each client, ask that one parent be identified as the responsible party (if insurance is billed this must be the holder of the insurance policy), and parents make payment arrangements between themselves according to their legal agreements.

Requests for Extra Account Reports: You will receive monthly statements. Please keep these for your records. If you need additional statements or billing reports, there will be a minimum charge of \$35 per report.

Insurance Reimbursement: Sue Ann Edwards is not a participating provider with any insurance network and does not accept payment from insurance companies. Clients who carry insurance are responsible for their own insurance reimbursement. However, I will provide you with the appropriate information and my billing service (see below) will assist you. It is important to understand that all financial agreements are between you and Sue Ann Edwards, not between Sue Ann Edwards and your insurance company. You are ultimately responsible for your bill.

We will attempt to assist you in billing your insurance for services that may be covered. (Insurance companies typically do not cover phone calls, collateral consultations, report writing, etc.) We are able to bill your insurance only for those services that have already been paid. We *cannot bill insurance to reimburse you for services for which you have not paid as that constitutes insurance fraud.*

Therefore, we will bill your insurance only after you have paid for services.

Office Hours & Telephone Contact: I am often not immediately available by telephone. While I am usually in my office between 10:00 am and 6:00 pm Monday through Friday, I likely will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call within 48 hours, with the exception of weekends and holidays.

Emergency Procedure: In case of an emergency, please call 9-1-1, call the San Diego Crisis Center at 1-800-479-3339, contact your personal physician or proceed to the nearest emergency facility *immediately*; do not wait to contact me by telephone. It is important to understand that we are not an emergency or crisis clinic and cannot respond as such.

Termination: You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. I ask that you contact me by phone if you make such a decision.

I have the right to terminate therapy with you under the following conditions:

- a) When I believe that therapy is no longer beneficial to you.
- b) When I believe that you will be better served by another professional. If possible, I will assist you in finding another qualified mental health professional.
- c) When you have not paid for the last two sessions, unless prior arrangements have been made.
- d) When you fail to show up for your last two therapy sessions without 24-hour notice.

If any of these situations apply, I will inform you of my decision and I will give you the names of other therapists for your future counseling needs.

CONSENT

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Date _____ Client's Signature _____

Date _____ Responsible Party's Signature _____

FOR PARENTS OF CHILD CLIENTS

1. When working with an individual child, I respect his/her right to confidentiality. I will consult with you regularly about your child's progress. Both parents are entitled to know the nature and progress of the child's therapeutic services. However, I recommend you not ask your children direct questions about their therapy experiences so as not to inhibit their participation or progress.
2. I will often speak with parents regarding their child and sometimes involve parents in their child's treatment. This should *not* be understood to mean that the parents are clients.
3. If I am seeing your child in individual sessions, please tell me prior to the beginning of the session whether there have been any unusual events since our last session or issues of concern you wish to discuss. This interchange must be brief so as not to interfere with the child's therapy session. If more time is needed, please call for a separate appointment or request a telephone consultation.
4. ***Please do not leave the office while your child is in session.*** Some children need to know that their parent is present for them in the waiting room and sometimes I involve the parent in a session. Your child may also need you to accompany them to the restroom. Children must be accompanied by an adult at all time while in the office complex. Sessions are typically 45-50 minutes in length.
5. Children should not be left unsupervised at any time and are not allowed to leave my office without adult supervision. Other professionals are doing work in adjoining facilities so I ask that my clients be respectful of their need for quiet and privacy. Food is discouraged in the office.
6. Since I often use art and play materials in therapy with children, please dress your child in clothing appropriate for messy play.
7. ***If your child may be ill, please cancel your appointment*** for the health of your child and others.

Consent to Treat Minor

I _____, as parent/guardian of minor child named _____, authorize and request Sue Ann Edwards, M.F.T. to carry out psychological examinations, diagnostic procedures, and/or treatments that are advisable now or during the course of his/her care as a patient. I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I have read and fully understand this consent form.

Date _____ Parent/Guardian Signature _____

Date _____ Parent/Guardian Signature _____

Involvement in Court Proceedings Waiver

The undersigned will neither individually nor jointly involve Sue Ann Edwards, M.F.T. in any litigation nor will she be requested or required to provide testimony in court. The reason for this is so that treatment is not compromised, the therapeutic relationship with the child & family is maintained, and the child experiences their therapist in a clear, consistent, therapeutic role and not as a detective. Sue Ann Edwards, MFT will not offer opinions, recommendations or reports regarding child custody.

Date _____ Parent/Guardian Signature _____

Date _____ Parent/Guardian Signature _____