Treatment Agreement

WELCOME: I encourage you to let me know, at any time, of any concerns or questions you may have regarding counseling and/or psychotherapy with me. I encourage clients to make a firm commitment to their healing process and to attend sessions on a regular basis. Weekly sessions, or bi-weekly if necessary, help to establish a firm foundation for the therapeutic relationship that we can create together.

FEES: The fee per 50 minute session is $_____, except for the 1st session. This is payable at the time of our session, unless I am billing your insurance, in which case you must pay your copayment and/or deductible at the session if applicable.

CANCELLATION: You may be charged $_____, not just a copayment) for sessions missed, cancelled without 24-hour notice, except in medical emergency. Insurance will not pay for missed sessions. You may be charged a fee if you were more than 15 minutes late, as insurance cannot be billed for that time.

INSURANCE: If I am a provider with your plan, I will submit claims for you, but at our session you must pay any portion not covered by your plan. If I am NOT a provider for your plan, you will pay me in full at the session, and I can give you an invoice so that you can seek reimbursement from your plan.

PLEASE SIGN IF USING YOUR INSURANCE OF EMPLOYEE ASSISTANCE PROGRAM (EAP)

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

(Sign here):

X_____

(If applicable, second client sign here): **X** _____

"I authorize payment of benefits to my provider." (Sign here): **X** _____

CONFIDENTIALITY: What you say in therapy, your records, and your attendance are all confidential. Exceptions include when your records are subpoenaed for legal reasons, when reporting is required or allowed by law (ex. suspected child/elder abuse or neglect, extreme danger to self, or danger to others), when you sign a release, and other exceptions as outlined in my Notice of Privacy Practices. In addition, the individuals named on the header and who are consulted on all client cases supervise Karie Klim, LMFT. Due to the nature of the therapeutic process and that it often involves discussing matters of a sensitive and confidential nature, I agree that should there be legal proceedings, neither I nor my attorney will call on Karie Klim, LMFT to testify in court or at any other proceedings, nor will we request disclosure of therapy records.

PHONE CALLS BETWEEN SESSIONS: 10-15 minute phone calls will not be charged for. Longer calls will be charged at the rate that we have agreed on for your regular counseling appointments with me.

EMERGENCY: Leave a voice message at 707-888-0106 if you need to contact me between sessions, and I will return your call within 24 hours. If you have a mental health emergency, please call the 24-hour crisis center in Sonoma County: (707) 576-8181, or the Suicide Prevention hotline at 1-800-255-2555.

ENDINGS: You may end therapy at any time, but a final phone call or session is requested for closure. It is my ethical duty to provide therapy only when your issues are within the scope of my training, when I feel you are actively participating in treatment, and when I feel you are benefitting from the sessions.

E-MAIL/TEXT: I do not do therapy by e-mail. I prefer to use e-mail/texting only to arrange appointments. When cancelling a session, please leave BOTH voicemail and e-mail messages. Please do not e-mail me information related to your therapy, as it is not completely confidential. Be aware that e-mails between us become part of your legal record.

SOCIAL MEDIA: I do not accept "friend requests" or contact requests from current or former clients on social networking sites (Facebook, LinkedIn, etc.) out of concern for your confidentiality and my privacy. It may also blur the boundaries of the therapy relationship.

SUBSTANCE USE: As we work together therapeutically, it is important that I be made aware of the role that alcohol or other addictive substances may play in the emotional state of any family members. If, during the course of counseling, it seems that substance use or abuse is inhibiting your ability to benefit from therapy, I may request that you participate in an additional recovery program as part of your therapy.

DISCLAIMER: I am not responsible for care received from professionals I refer you to. Our agreements do not involve other providers in the suite, who operate solo independent practices (we are not a group).

PRIVACY POLICY: By signing below, you acknowledge 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 in full. My Notice of Privacy Practices 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 the above address. If you have questions about the Notice or any of the above, feel free to ask.

CONSENT FOR TREATMENT: I understand that Karie Klim is a Licensed Marriage & Family Therapist. I have discussed my areas of concern with her and have willingly chosen to use her services. I agree to discuss any questions or problems with Ms. Klim should they arise during the course of therapy. I understand that if Ms. Klim is unavailable due to any emergency that her a pre-arranged confidential colleague may call me to let me know. I have read and understand these office policies and procedures regarding therapy and I have been advised of my right to confidentiality and its exceptions.

_____

Client Signature Date

_____

Responsible Person/ Guardian Date

CONTACT INFORMATION	**Best Time To Call**	**Permission to Leave Message**
Home Phone: _____	_____	❑ Yes ❑ No
Cell Phone: _____		❑ Yes ❑ No
Work Phone: _____		❑ Yes ❑ No
e-Mail: _____		