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TREATMENT AGREEMENT

Client Name: _____

Please initial in each box on the left after reading the text to the right:

INITIAL BELOW	
	FEES: The private fee per 60-minute session is $130. This is due at the time of our session in cash or check or credit card (*unless I am billing your insurance or EAP)*. Fees are the same for video, phone, or in-person sessions.
	CANCELLATION: Sessions are by appointment only. While I hate charging for missed sessions, I do reserve that time for you. Therefore, you will be charged $130 (not just a copayment) for missed sessions or for those cancelled without 48-hour notice, except in medical emergency. A medical emergency is defined as an acute injury or illness that poses an immediate risk to a person's life or long-term health, sometimes referred to as a situation risking "life or limb." These emergencies may require assistance from another, qualified person as some of these emergencies cannot be dealt with by the victim themselves. Insurance will not pay for missed sessions. If you are an EAP client, sessions will be billed for less than 48 hour notice, no-shows, and non-life-threatening illness. If you develop a pattern of missed sessions, I will discuss with you and you may choose to discontinue until your schedule is more stable. Since your time is also valuable, if I err and absent a session, you will receive a complimentary session. This is not my track record, however. My appointments run on the minute. If I run late, I will notify you and adjust the appointment length fairly.
	INSURANCE: If I am a provider with your plan: The only insurance plan I am a provider for is Carelon/Partnership HealthPlan. I will submit claims for you. If insurance does not pay as expected, you remain responsible for the balance. You have the right to waive using insurance coverage, if desired. Please ask for a waiver, if so. **If I am NOT a provider for your plan:** You will pay me in full at the session. I can give you an invoice if you wish to seek reimbursement from your plan. Many plans do not cover sessions with a provider who is not in their network.
	DIAGNOSIS: Please be aware that if you use insurance, I will be required to provide a diagnosis on invoices and claims, and coverage may be limited to certain mental conditions that are covered by your plan.
	LIMITS OF MEDICAL COVERAGE: Even if you have insurance coverage for unlimited sessions, health plans may review treatment for medical necessity, limit length of treatment or frequency of sessions, and request treatment notes. While I may check coverage for you, you are responsible for verifying and understanding the limits of your coverage. Although I am happy to assist your efforts in obtaining insurance reimbursement, I am unable to guarantee whether your health plan will provide payment for the services provided.
	CONFIDENTIALITY: What you say in therapy, your records, and your attendance are all confidential. Exceptions to confidentiality include when records are subpoenaed for legal reasons, or when you give written permission to release information. The law may require reporting of suspicion of child abuse or neglect; bullying; when there is downloading, streaming, or accessing material in which a child is engaged in an obscene or sexual act; danger to self; suspected domestic violence, elder abuse, or danger to others. I may consult with other professionals on your case, but would keep your identity confidential, or get a release from you. See other exceptions in my *Notice of Privacy Practices.*
	IN AN EMERGENCY: You may inform me of your emergency via text, e-mail and voicemail. But, it is best to proceed directly where you can receive care to the emergency room or dial 911.
	TEXT/E-MAIL/SOCIAL MEDIA: In general, texting is the most direct way to reach me and acquire a timely response. I use any modality (text, email, or voice), however, to arrange/change appointments. **If you are voice messaging, please also email the notice.** I do not do therapy by e-mail or video. Please do not e-mail me information related to your therapy, as e-mail is not completely confidential, and Important issues should be reserved for sessions. Be aware that e-mails between us become part of your legal record. I do not accept friend requests or contact requests from clients on social networking sites (Facebook, LinkedIn, etc.) out of concern for your confidentiality and my privacy. It may also blur the boundaries of our therapy relationship.

Client Name: _____

INITIAL BELOW	*Treatment Agreement (continued from Page 1)*
	SESSION NOTES: I am legally and ethically required to keep notes about what is said in session, what actions I take, and what advice is given to you in each session. If you have concerns about these notes, please feel free to ask.
	LEGAL MATTERS: If you become involved in legal proceedings that require my participation, you agree by signing this Agreement to pay me at my regular full fee of $130 per hour for any time I must spend on your case, including but not limited to time spent to prepare summaries, to appear in court or give depositions, travel time to and from such proceedings, and lost income for sessions I must miss.
	REFERRALS/GROUP: A referral to another provider may become necessary if it becomes clear in my opinion that your issues would be better treated by a professional with different expertise. It is unethical for me to practice beyond the level of my competence, education, training, or experience. I am not responsible for the care received from professionals to whom I refer you.
	ENDINGS: If you are unhappy with any aspect of therapy, I ask that you talk to me to see if we can work it out. Even if we can't, endings usually feel better this way. Of course, you may end therapy at any time, and I will assist with referrals. It is my ethical duty to provide therapy only when I feel you are participating and benefiting from sessions. I may end treatment if there have been repeated no-shows, late-cancellations, or other treatment interruptions.
	PATIENT RIGHTS: You have the right to ask any questions about your treatment or refuse to participate in treatment at any time. This office does not discriminate in the delivery of health care services based on race, ethnicity, national origin, citizenship or immigration status, religion, gender/gender identity, age, mental or physical disability, medical condition, sexual orientation, medical history, evidence of insurability, or source of payment.
	COMPLAINTS: • **The CA Board of Behavioral Sciences** receives and responds to complaints regarding services provided within the scope of practice of Marriage and Family Therapy. You may contact the board online at https://www.breeze.ca.gov/datamart/mainMenu.do, or by calling (916) 557-1208. • **The Idaho Board of Professional Counselors and Marriage and Family Therapists** receives and responds to complaints regarding services provided within the scope of practice of Marriage and Family Therapy. You may contact the board online at https://dopl.idaho.gov/cou/, or by calling (208) 334-3233. • **The Utah Marriage and Family Therapy Division of Licensing** receives and responds to complaints regarding services provided within the scope of practice of Marriage and Family Therapy. You may contact the board online at https://dopl.utah.gov/marriage-and-family-therapy/, or by calling (801) 530-6628.
	PRIVACY PRACTICES: By initialing here and signing below, you are acknowledging receipt of my *Notices of Privacy Practices*. My *Notice of Privacy Practices* 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 and phone number

Client Name: _____

PLEASE SIGN THE FOLLOWING IF USING YOUR INSURANCE: *"I authorize the release of any information necessary (Including notes, treatment summaries and diagnosis) to process insurance claims, to prove medical necessity for treatment, to request additional sessions, or to comply with treatment reviews or administrative chart reviews from the insurance plan. If my therapist is a network or EAP provider, I authorize payment of benefits to be made to her." Sutter Health EAP program will never request the release of any information necessary (Including notes, treatment summaries and diagnosis) to process sessions to prove medical necessity for treatment, to request additional sessions, or to comply with treatment reviews or administrative chart reviews from the program.*

(Sign here) :**X** _____

If second client participating, sign here: **X** _____

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

By signing below, I acknowledge that I have read and understand the above rights and policies.

_____	_____	_____
Signature	Printed Name	Date
_____	_____	_____
Signature, second client (if applicable)	Printed Name, second client (if applicable)	Date