

Stephanie Patterson, MS, LMFT

Licensed Marriage and Family Therapist in California LMFT 86018

671.929.1222

Introduction

Welcome! This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask any questions during your appointment that you may have regarding its contents.

By signing this document I give permission to Stephanie Patterson, MS, LMFT #86018 to provide online counseling services to myself, family, and/or my minor child. I understand that she is a Licensed Marriage and Family Therapist in the state of California.

Definition of online therapy/counseling

Online therapy/counseling involves the use of electronic communications to enable your therapist to connect with individuals using interactive video and audio communications. Online therapy includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

Confidentiality

All communications between you and your therapist will be held in strict confidence unless, you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you were to provide their written authorization to release such information. However, it is important that you know that your therapist utilizes a “no-secrets” policy when conducting family or marital/couples therapy. This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with her, when working with other members of your family. Please feel free to ask about this “no secrets” policy and how it may apply to you.

There are exceptions to confidentiality. Therapists are required to report suspected child, adult dependent, elder abuse, or if mandated by a judge.

Therapists may be required or permitted to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person or when a client is a danger to self.

Minors and Confidentiality

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child’s treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his professional judgment, may discuss the treatment progress of a minor patient with the parent or caregiver. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hours in advance of your appointment. If you do not provide your therapist with at least 24 hour notice in advance, you are responsible for payment for the missed session.

Fees

Individual Sessions and conjoint (marital /family) sessions are approximately 50 minutes in length. Fees are payable at the time that services are rendered. Please ask if you wish to discuss a written agreement that specifies an alternative payment procedure.

The fee for service is \$120.00 per session per 50mins.

80 minutes sessions are \$175

30 min sessions are \$75

Initial assessment session will be \$135.00 and approximately 50 mins. in length.

I accept all major credit cards. Credit cards will be stored in a secure electronic vault. Your card will automatically be charged at the time of appointment for payments due.

Without 24 hour notice of cancellation, with an exception to emergency situation, you will be charged the full session fee.

I am willing to provide a super-bill for you to submit to your insurance. However, please note, the insurance re-imburement will be at a different rate than my fee.

Additional letters or documentations preparations will be charged at \$200 hourly rate, which are not necessarily reimbursed by your insurance company.

Therapist Availability/Emergencies

Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions.

You may leave a message for your therapist at any time on her confidential voicemail. If you wish for your therapist to return your call, please be sure to leave your name and the phone number(s), along with a brief message concerning the nature of your call.

To keep you safe during sessions, you will be expected to identify an appropriate support person, your own identity, location, and phone number while using video-conferencing. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Consent for Treatment/Therapy Process

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. You have the right to agree or disagree with your therapist's recommendations. Therapists and patients are partners in the therapeutic process. Sometimes it occurs that patients will feel worse before feeling better. Sometimes despite your efforts and the efforts of your therapist, your condition may not improve, and in some cases may even get worse.

Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion. Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

If your therapist believes you would be better served by another form of intervention (e.g., face to face therapy), you will be referred to a mental health professional that can provide such services in your area.

Please note there are risks and consequences from online therapy, including, but not limited to the possibility, despite reasonable efforts on the part of the therapist, that; the transmission of your personal information could be disrupted or distorted by technical failures, the transmission of your personal information could be interrupted by unauthorized persons, and/or electronic storage of your personal information could be unintentionally lost or accessed by unauthorized persons.

You have the right to access your medical information and copies in accordance with the laws pertaining to the state of your legal residence.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve.

It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

During your initial phone call, alternatives to online therapy were explained and a goodness of fit for online therapy was assessed. In choosing to participate in online therapy you are agreeing to participate in using video conferencing technology.

Your signature indicates that you have read this agreement for services carefully and understand its contents. Please ask your therapist to address any questions or concerns that you have about this information before you sign.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____