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AKA, Deborah Powers Neighbors
Licensed Marriage and Family Therapist #52958, Substance Abuse Professional
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Disclosure Statement & Agreement For Service

Introduction

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents. Your therapist is a Licensed Marriage and Family Therapist in the State of California. At the appropriate time, your therapist will discuss her professional background with you and provide you with information regarding her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience, and professional orientation.

INSURANCE: In Network Fee

____ (Initial) _____ co-payment, bill my insurance; I accepts the terms of my insurance.

Please inform your therapist if you wish to utilize health insurance to pay for services. If your therapist/provider is a contracted provider for your insurance company, your therapist/provider will discuss the procedures for billing your insurance.

Cash/Credit Card Fees

DOT and NON-DOT must pay in Cash and have Credit Card on file for Non-Compliance

____ (Initial) $350 DOT Violation Evaluation/Includes Initial Letter to Employer
____ (Initial) $250 DOT Violation Back-To-Work Interview/Includes Letter to Employer
____ (Initial) $500 DOT Evaluation if paid in cash in advance for both appointments/ 2 reports
____ (Initial) $ 35 15 minutes of texting time or phone calls regarding non-compliance
____ (Initial) $150 Reports or letters to the Court/Employer/School/Non-Compliant DOT Reports
____ (Initial) $150 Per hour for additional phone work, non-compliance letters, and arrangements

Individual

____ (Initial) $190 First Visit per **Individual session** (50 minutes)
____ (Initial) $150 **Individual session** (50 minutes)

Family or Couple

____ (Initial) $250 **Couple** or Family session (50 minutes) or

Executive Addiction Therapy Program Intervention

____ (Initial) $200 per hour (Minimum 2 hours) **Phone consultation and Rehab coordination,** I agree, that while I am being monitored for sobriety by Debbie Powers LMFT, if, I relapse, and my family member calls this therapist for help, and I need to be placed into the hospital or a rehab, I will allow payment to be applied to my credit card that I have on file with Debbie Powers LMFT.

Group

____ (Initial) $ 50 **Group** session (55 minutes)

Your therapist will only provide a Super bill for Out of Network. The amount of reimbursement and the amount of any co-payment or deductible depends on the requirements of your specific insurance plan. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist/provider is happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you and we only provide a Super bill, no out of network claims will be provided. _____ (Initial) Please discuss any questions or concerns that you many have about this with your therapist. If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

Confidentiality

All communication 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 provide their written authorization to release. (Your therapist will not disclose information communicated privately to him or her by one family member, to any other family member without written permission.) There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when she has determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act. 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 participate in the treatment with you 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/couple 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 him or her, when working with other members of your family. Please feel free to ask your therapist about his or her "no secrets" policy and how it may apply to you. If I learn that any minor is having sexual relations with an adult, or with another minor when there is a significant disparity in age or maturity level between them, I may be required to report this to a county or state agency. If I hear about a serious threat of physical violence against another person, I am required to inform law enforcement and the potential victim. If you are involved in a legal proceeding, I may be required by the court to release certain information, and other situations where I may have a legal duty to divulge information.

Sometimes, insurance companies and managed care companies ask for information about a client's treatment, and such requests may include psychotherapy notes. By signing this informed consent form below, you authorize me to provide any and all information regarding your treatment requested by your insurance company and/or managed care company. If I die or become unavailable for any reason, I have an arrangement in place such that another mental health professional will review and take possession of your file and treatment records. If appropriate, he or she will refer you to other therapists for the continuity of your care. This professional will also deliver your file and records to another therapist of your choice.

Client's Bill of Rights

Under HIPAA, a patient generally has a right to inspect and obtain a copy of his or her individual "protected health information (PHI)" with a few exceptions. PHI includes, but is not limited to, information created or received by a health care provider that relates to the past, present, or future physical or mental health or condition of an individual, including payment of services, that identifies the patient; or information that can be used to identify the patient. PHI also includes demographic information collected from the patient.[4]

- A patient does not have the right to access "psychotherapy notes" (this term is defined below);
- A patient does not have the right to access information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
- If you work for a correctional institution, you may deny an inmate patient's request to obtain PHI if doing so would jeopardize the health, safety, security, custody, or rehabilitation of the patient or other inmates, or safety of any officer, employee, or other person at the correctional institution or responsible for transporting the inmate;
- The PHI is obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

Informed Consent and 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 or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients 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, Credit Card on file Approval

Sessions are typically scheduled to occur one time per week at the same time each week if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. 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 lease 24 hours notice in advance, you are responsible for late cancellation payment of $75 for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions. If you do not show up or fail to cancel your appointment within 24 hours in advance by calling in to 949-249-8888, a $75 cancellation fee and will be charged to your on file credit card. You agree to allow your therapist to charge your on-file credit card for co-payments and missed appointments. _____ (Initial)

If I perform additional professional services relating to your therapy, it is my practice to charge you for that time. For example, if I consult with other professionals about your case, I may charge you, although I generally do not charge for short consultations. I charge $150 per hour; prorated for the time I actually spend performing these services.

I will also charge you for time that I spend on any legal matters or proceedings relating to your treatment. This includes time that I spend responding to a subpoena, producing medical records, preparing to testify, traveling to testify, or testifying in any proceedings—regardless of which party sought my involvement in the case. Because of the added difficulties posed by legal proceedings, I charge $200 per hour for my involvement in these matters.

If a bill for my services goes unpaid, I will begin to add late fees to the bill. If a bill is not paid within 90 days of the service, I will add a late fee of $25. Additional $25 late fees will accrue for every additional 90-day period in which the bill goes unpaid. I reserve the right to refer unpaid bills to a collection agency. If your check is declined, I will ask you to pay the $25 or bank fee charges.

Therapist Availability/Emergencies

Telephone consultation between office visits is 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. In the event of a medical emergency or emergency involving a threat to your safety or the safety of others, please, call 911 to request emergency assistance.

About the 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 recommendation to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. 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.

The Therapeutic Relationship

In order to provide you with the best mental health services that I can, the ethical rules of my profession require that I maintain a professional and therapeutic relationship with you. I may not have any other type of relationship with you, such as a social, personal, friendship, or business relationship. Such relationships would undermine the effectiveness of therapy. Also, if I see you in public, I will not acknowledge your presence unless you address me first. This is simply to protect your confidentiality—i.e., the fact that you are my client. This is your therapy time, please; do not feel offended if I refuse to disclose personal information about myself.

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 and your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternative. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or termination of therapy.

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.

Contact information

By entering the contact information below, you agree that I may communicate with you at the following addresses and telephone numbers. Any mail that is sent to the address below will bear my name and return address; I will also identify myself on any voicemail systems or telephone answering machines. If any changes are made to these arrangements, please let me know immediately.

Mailing address: _____

Email address: _____

Telephone number(s): _____

Consent to treatment

By signing below, you agree to participate in psychotherapy with me. You also acknowledge that you have read, understood, and agree to the terms contained in this informed consent form. You also acknowledge that you have ample opportunity to ask questions and seek clarification about our therapeutic relationship.

Client's signature: _____

Printed name: _____

Date: _____

If a client's personal representative, rather than the client himself or herself, is signing this form, please describe the personal representative's authority to provide this consent.

_____