Uplifting Therapy

Licensed Marriage and Family Therapist
Brenda Franks Lic. # LMFT 96217
PH: 530.645.2278 FAX: 530.441.1277

INFORMED CONSENT

Welcome to my practice, I appreciate you giving me the opportunity to be of help to you. This document contains important information about my professional services and business policies. Please read it carefully and ask any questions you may have so that we can discuss them. Signing this document will represent an agreement between us.

Therapy is not easily described in general statements. It varies depending on the personality of the therapist and patient, and the particular problems you bring up. There are many different methods I may use to deal with the problems you hope to discuss. Therapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. There is also no predictable time table in which change occurs, and the process of change may be slow and frustrating. In order for therapy to be most successful, you will have to work on things we talk about during session, outside of sessions.

As with any treatment, therapy can come with risks and benefits. Change can be scary and uncomfortable and can cause disruption to existing relationships. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration and helplessness. On the other hand, therapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems and significant reductions in feelings of distress. There are no guarantees what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow. You, of course, may discontinue or terminate therapy at any time for any reason.

Sessions: The sessions will usually be one 45-50-minute session as needed. There is a 24-HOUR CANCELLATION POLICY, WHICH REQUIRES YOU CANCEL YOUR APPOINTMENT 24 HOURS IN ADVANCE TO AVOID THE FULL FEE OF A SESSION, WHICH WILL BE DUE ON YOUR NEXT APPOINTMENT.

Billing: You will be responsible to pay _____ discussed in our agreement at the end of each session or service. I will give you a receipt if you would like one. Additional fees will be incurred for other services such as report writing, telephone conversations, attendance at meetings with other professions you have authorized, preparations of records or treatment summaries, and the time spent performing **any** other service you may request of me. *If you become involved in legal proceedings that require my participation, you will be expected to pay $125 hourly for my professional time even if I am called to testify by another party.*

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All payments are to be made in cash, check or credit card. If a check is returned for insufficient funds, a $35 fee will be charged.

Insurance: Please inform me if you wish to utilize health insurance to pay for services. If I am a contracted provider for your insurance carrier, I will discuss the procedure for billing insurance. The amount of reimbursement and the amount of any copayments or deductibles depends on the requirements of your specific insurance plan. In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. I will provide whatever information I can based on what I am told by my billing company; however, it is very important for **you** to find out exactly what mental health services your insurance policy covers. Insurance benefits have increasingly become complex. **It is sometimes difficult to determine exactly how much mental health coverage is available, however you, (not your insurance carrier) are responsible for full payment. I am unable to guarantee whether your insurance will provide payment for the services provided to you.**

If I do not accept your insurance, I can provide you with a superbill. Some patients can receive a portion of counseling fees reimbursed for "out of network" care to them from their insurance companies. Many patients will not receive reimbursement for various reasons; being reimbursed the full fee is extremely rare.

Contacting me: I am often not immediately available by telephone. You can always leave a message on my confidential voicemail box and I will return your call as soon as I can. If you have an emergency or crisis and cannot reach me, you or your family should call one of the following community emergency agencies; Sutter Yuba Behavioral Health's crisis line at 530-673-8255 or 911.

Records: The laws and standards of my profession requires that I keep treatment records. Insurance companies will sometimes ask for more information on symptoms, diagnoses, and my treatment methods. It will become part of your permanent medical record. I will let you know if this should occur and what the company has asked for. Please understand that I have no control over how these records are handled at the insurance company. My policy is to provide only as much information as the insurance company will need to pay your benefits. Patients will be charged an hourly fee of $120 an hour, my customary hourly rate, for any professional time spent in responding to information requests.

Minors and Parents: If applicable, I will provide parents/guardians a summary of the progress of therapy, but any other communication will require the child's authorization. If I feel that the child is in danger or is a danger to someone else, I will notify the parents of my concern.

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Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections that he/she may have.

Confidentiality: The law protects the information that is shared between a therapist and patients. Any information you disclose to me during treatment, or any information I obtain while providing care, in compliance with HIPAA, is to be held confidential unless you allow me to disclose such information, in which I would need a Release of Information (ROI) from you. You may write a request to withdraw the ROI anytime you choose. I may be allowed or required by law to disclose confidential information without your consent in certain situations. *If I believe a child, elderly person or a dependent adult, has been or will be abused or neglected, I am legally required to report this to authorities.

If you make a serious threat to harm yourself or another person, the law requires me to protect the other person. **If you are involved in court proceedings and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court-order. ***In some cases, in which parents of a minor are divorced or separated, the parent/parents who have legal custody may have the right to receive general information about the treatment of a minor.

BBS Notice to Patients: The Board and Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Professional Will/Professional Executor: In case I am suddenly unable to continue to provide professional services or maintain patient records due to incapacitation or death, I have designated a colleague who is a licensed therapist as my professional executor (PE). If I die or become incapcitated, my PE will be given access to all of my patient records and may contact you directly to inform you of my death or incapacity, to provide access to your records, to provide psychological services if needed, or to facilitate continued care with another qualified professional if needed. If you have any questions or concerns about this PE arrangement please let me know.

Our Agreement: I, the patient (or his or her parent guardian), understand I have the right not to sign these forms. My signature below indicates that I have read and discussed this agreement; it does not indicate that I am waiving any of my rights. I understand that any of the points mentioned above can be discussed and may be open to change. If any time during

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treatment I have questions about any of the subjects discussed in the Informed Consent, I can talk with you them, and you will do your best to answer them.

I understand that after therapy begins, I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy.

_____ _____

Signature of patient Date

_____

Printed Name

_____

Brenda Franks, Licensed Marriage and Family Therapist #LMFT 96217

A copy of the Notice of Privacy Practices was provided to the patient.

_____ _____

Signature of patient Date