Community Family Therapy – Maria Mishkind, CA License LCS 238-17

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**OFFICE POLICIES & GENERAL INFORMATION AGREEMENT**

**CONFIDENTIALITY:** Information disclosed in therapy sessions and the written records pertaining to those sessions are generally confidential and will not be disclosed unless the disclosure is mandated or permitted by law. You may choose to give me written permission to do so for referral purposes, etc. The following are examples of some of the reasons that **DISCLOSURE IS REQUIRED BY LAW** as a result of my mandated reporter status:

1. Where there is reasonable suspicion of anyone (inside or outside of therapy – outside could include neighbors, friends) is experiencing child physical, sexual, or emotional abuse or neglect.
2. Dependent adult abuse.
3. Elder abuse (age 65 and older).
4. If you present an imminent danger to someone else or their property.
5. If you present imminent danger to yourself and/or are gravely disabled.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(initial here)

**DISCLOSURE MAY BE REQUIRED BY LAW** pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain my psychotherapy records and/or require my testimony. In couple and family therapy, or when different family members are seen individually, there is a no secrets policy. This means confidentiality and the privileged disclosure of it do not apply between the couple or among family members. I will use my best clinical judgment when revealing such information. I will not release records to any outside party unless I am authorized to do so by all adult family members who are part of the psychotherapy session in question.

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**IN THE EVENT OF A CRISIS**, if you are in need immediate help during our work together, or even after we stop working together, where I become concerned about;

1. Your personal safety
2. The possibility of you harming yourself or someone else
3. You needing psychiatric care

I will do whatever I can, within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive proper care. For the purpose, I have your signature(s) on page 4 as approval to contact the emergency contact that you listed on the Clinical Intake Form, which you have also completed.

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**DUAL RELATIONSHIPS**

Therapy never involves sexual or business relationships or any other dual relationship that impairs my objectivity, clinical judgment, therapeutic effectiveness or that can be exploitative in nature.

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**MENTAL HEALTH INSURANCE AND CONFIDENTIALITY OF RECORDS:**

Disclosure of confidential information may be requested by your health insurance carrier or HMO/PPO/MCO/EAP in order to receive reimbursement for therapy. If you instruct me to disclose information, I will release only the minimum information necessary to receive reimbursement. I have no control or knowledge over what insurance companies do with the information I submit, or who has access to the information submitted. You are hereby notified that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality privacy and possibly the future capacity to obtain health or life insurance. The inherent risk is because the information is entered into insurance companies’ databases. The Health Insurance Portability and Accountability Act (HIPAA) is designed to give companies and the Federal Government access to your mental health and physical health records. Access to the systems my pose a risk to you. There have been reports of stolen and sold data.

If I am a provider with your plan, I will submit claims for you, but at our session you must pay ant 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.

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| **PLEASE SIGN IF USING YOUR INSURANCE OR EMPLOYEE ASSISTANCE PROGRAM**  “I authorize the release of any information necessary (including notes, treatments 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Email and Text use** – If you choose to communicate with me by e-mail or text, then you release me from liability of lost and/or misplaced emails and texts that may be read by others. I cannot maintain confidentiality on computers or phones that are not in my possession (i.e. your phone/computers). If you would like to communicate by email or text, then please initial here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RECORD KEEPING AND YOUR RIGHT TO REVIEW RECORDS**

Both the law and the standards of my profession require that I keep appropriate records regarding the nature and content of psychotherapy sessions. However, working with your ingoing process in the “here and now” does not always translate well to the criminal or civil justice system. If you are planning to use the information collected in sessions for legal proceedings of any kind, it will be less content and more fact based such as general themes that were discussed and what dates you showed up for therapy. Upon written request, you have the right to review or receive summary of your records at any time, except in limited legal or emergency situations, or if I assess that the release of information might be harmful. In such a case, as is appropriate, I will provide the records to an appropriate and legitimate mental health profession of your choice. Considering all of the above seclusions, if it is still appropriate, upon your request, I will release information to any agency/person you specify, unless I assess that doing so might be harmful. Once I receive a request in writing, I legally have 10 days to provide them to you or to an agreed 3rd party recipient. You have the right to rescind any written release at any time.

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**LITIGATION LIMITATION**

You are the holder of the psychotherapist/client privilege. If I should receive a subpoena for records, deposition, testimony or testimony in a court of law, I will assert the psychotherapist-patient privilege. Due to the nature of psychotherapy, the sensitivity within it, and to protect your confidentiality, it is hereby agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc..), neither you nor your attorney, nor anyone acting on your behalf will call on me to testify in court, or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. You are also financially responsible for any fees involved in sending registered letters, US mail postage, UPS or Fed-Ex envelopes for legal purposed sent at your request. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (initial here)

**CONSULTATION**

To be ensured of support of ethical work, I regularly consult with other professionals in the field regarding my work; however, names and other identifying information are never revealed – identities and confidentiality are always maintained.

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**THERAPIST VACATION/BUSINESS TRAVEL**

I am out of the office about six weeks each year to do travel related to professional development and personal vacation. Generally, I give several weeks notice of my plans and I rarely take more than 2 weeks off at a time. Before I leave, we will discuss whom to contact and what to do in a crisis situation.

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**TELEPHONE AND CRISIS PROCEDURES**

If you need to contact me in-between sessions, I check voicemail at least 1x/day and will return your phone call generally the same day or within 24 hours. If this does not occur for whatever reason, or you need immediate assistance please call the Suicide Prevention Service crisis hotline at 1-877-663-5433 or call 911.

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**FEES AND APPOINTMENT LENGTH**

My fee is $\_\_\_\_\_ for each 50-minute session. Fees for services will be discussed, and agreed upon during the initial consultation 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 you are late for your appointment, we will still stop on time so that we will not infringe on other client’s time.

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**PAYMENT**

Unless other arrangements are made, payment for services is expected at the time they are rendered. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading of records, extended sessions, travel time, etc. will be charged at the same rate, unless otherwise agreed upon.

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**CANCELLATIONS AND MISSED APPOINTMENTS**

You may be charged $100.00 (Not just a copayment) for session missed or cancelled without 48 hours notice, except in medical emergency. Insurance will not pay for missed sessions.

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**MEDIATION AND ARBITRATION**

All disputes arising out of or in relation to this agreement to provide psychotherapy services shall be referred to mediation, before, and as a precondition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement between us. The cost of such mediation shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement will be submitted to and settled by binding arbitration in Monterey County, California, in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the forgoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, I may use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in an arbitration or collection proceeding shall be shall be entitled to recover a reasonable sum as and for attorney’s fees. In the case of arbitration, the arbitrator will determine the sum.

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**THE PROCESS OF THERAPY AND EVALUATIONS**

Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specifics that bring you to therapy. Working toward these benefits; however requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness so that you can change the thoughts, feelings, and behaviors. I will expect you to respond openly and honestly. I use a variety of theoretical orientations and interventions depending on the issue and any preferences you specify. During evaluation or therapy, recalling or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, anxiety, depression, insomnia, etc. I may challenge some of your resumptions or propose different ways of thinking or handling situations, which can cause you to feel upset. Attempting to resolve issues that brought you to therapy may result in changes that you had originally not intended. Psychotherapy may result in changes that you had originally not intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed negatively by another family member or by friends. Change will sometimes be easy and fast, but more often it will be slow and even frustrating, as breaking long-held patterns can be difficult. Often you may feel worse as you start to become more aware and conscious of the issues at hand, before feeling better. There is no guarantee that psychotherapy will yield positive results or intended results. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

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**DISCUSSION OF GOALS AND PLANS**

Within reasonable time after our first meeting, we will discuss my working understanding of the problem, a plan of action, possible outcomes and a potential time-line. If you have any unanswered questions about any of the events in the course of therapy, possible risks, my expertise, or about the plan and goals, please ask and you will receive a full and honest response. You also have the right to ask about other approaches to the resolution of your issues and their risks and benefits. If you could benefit from any treatment I do not provide, I have an ethical obligation to assist you in obtaining those interventions.

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**TERMINATION**

As noted above, after the first couple of meetings, I will assess if I can be of benefit to you. I do not work with people who, in my opinion, I cannot help. In such a case, I will do my best to give you up to (3) referrals that you can contact. If at any point during therapy I assess that I am not effective in helping you reach your goals, I am obligated to discuss it with you, and if appropriate, end our work together. If you request it and authorize in writing, I will talk to a referral source of your choice in order to help with the transition. If at any time you want another professional’s opinion or wish to consult with another therapist, I will assist you in finding someone qualified and if I have written permission, I will provide her or him the essential information needed. You have the right to end therapy at any time. If you choose to do so, I will offer referrals as noted above. If, in the unlikely event, that I become incapacitated, or die, a trusted licensed therapist colleague will contact you on my behalf with a plan for your care.

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**I HAVE CAREFULLY READ THE ABOVE POLICIES; I UNDERSTAND THEM AND AGREE TO THEM:**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist Signature \_\_\_\_\_\_\_\_\_\_\_\_\_ date