SIERRA PSYCHSOLUTIONS
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AGREEMENT FOR SERVICE / INFORMED CONSENT FOR MINORS

This Agreement is for the purpose of outlining the terms and conditions of services to be provided by SierraPsychSolutions,_____LMFT for the minor child(ren) _____ and is intended to provide Parent/Guardian_____with important information regarding the practices, polices and procedures of SierraPsychSolutions,_____LMFT and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Policy Regarding Consent for the Treatment of a Minor Child

Therapist generally requires the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of Representative to give consent for psychotherapy, Therapist will require that representative submit supporting legal documentation, such as a custody order, prior to the commencement of services.

Psychotherapy is an invitation to discuss issues, events, and experiences for the purpose of creating positive change enjoy life more fully. It provides an opportunity to understand oneself, as well as, any problems or difficulties you may be experiencing. Psychotherapy is a collaborative effort between you and your therapist. Progress and success will be discussed throughout your treatment at SierraPsychSolutions. If therapy is challenging your comfort level or you are not benefitting from therapy—please discuss this with your therapist.

Participating in therapy involves discussing events, feelings and experiences. It also involves identifying your thoughts, needs, and beliefs. The process can evoke many feelings—which are all welcome at SierraPsychSolutions. We encourage healthy discussions about the dynamics in your life. Sometimes therapy creates an environment that facilitates changes in personal relationships. We encourage you making your own healthy decision(s) on the status of your personal relationship—which you are completely responsible for.

Parents: When working with your child/children, we will consult with you on an as needed or requested basis. We encourage your participation as long as it is beneficial to our client. If it is not beneficial, we will have a conversation about how to best support your child/children as well as your role as a parent(s).

Professional Consultation

When we consult with other professionals, we do not use any identifying information.

Records and Record Keeping

Notes may be taken during session. We will keep other notes and records regarding your treatment. These notes constitute clinical and business records, which by law, we are required to maintain. Such records are the sole property your therapist. We will not alter your normal record keeping process at the request of any patient. If you want a copy, please request in writing. Therapists at SierraPsychSolutions reserve the right, under California law, to provide you with a treatment summary in lieu of actual records. We also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Your records will be maintained for seven years following termination of therapy. After seven years, your records will be destroyed in a manner that preserves your confidentiality. For minors, we may choose to keep your records until you turn 18. At that point, we will either destroy those records or have a discussion about what you would like to do with your record as an adult.

Confidentiality

The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.

Patient Litigation

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient and another individual, or entity, are parties. WE have a policy of not communicating with your attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in legal matters. Generally we do not provide records or testimony unless compelled to do so. If your therapist is subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse your provider for any time spent for preparation, travel, or other time in which your therapist has made him/herself available for such an appearance at a usual and customary hourly rate of 120.00 per hour

Psychotherapist-Patient Privilege

Any records created by your therapist are subject to the therapist-patient privilege. The therapist-patient privilege results from the professional relationship between your therapist and you. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically you are the holder of the therapist-patient privilege. If a subpoena for records is received, deposition testimony, or testimony in a court of law, your therapist will assert the therapist-patient privilege on your behalf until instructed, in writing, to do otherwise by you or your representative. Please be aware that you might be waiving the psychotherapist-patient privilege if you make your mental or emotional state an issue in a legal proceeding. Please address any concerns regarding the therapist-patient privilege with your attorney.

Fee and Fee Arrangements

The usual and customary fee for service is 120.00 per 50-minute session. Sessions longer than 50-minutes are charged for the additional time pro rata. Periodically, we reserve the right to adjust this fee. You will be notified of any fee adjustment one month in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payors, or by your therapist.

The agreed upon fee between Therapist and Patient/Representative is_____.

Any phone calls longer than 15 minutes will be billed 50.00 per half hour.

Payment for services(including copays) are expected at the time services are rendered. We accept cash, checks, and major credit cards.

Insurance

You are responsible for any and all fees not reimbursed by your insurance company, managed care organization, or any other third-party payor. Please note your are responsible for verifying and understanding the limits of your coverage, as well as co-payments and deductibles. If you want to use your insurance and agree to the contracted rate, please inform your therapist—otherwise you will be charged the standard/agreed upon rate.

We will supply you with a super bill if you choose not to use insurance.

Cancellation Policy

Representative is responsible for payment of the agreed upon fee for any missed session(s). Representative is also responsible for payment of the agreed upon fee for any session(s) for which Representative failed to give Therapist at least 24 hours notice of cancellation.

If you cancel with less than 24 hours notice, you will be charged for that appointment time.

Cancellation notice should be left on telephone number provided.

Therapist Availability

SierraPsychSolution's office is equipped with a confidential voice mail system that allows you to leave a message at any time. We will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. We do not provide 24-hour crisis service. In the event that you are feeling unsafe or require immediate medical or psychiatric assistance, call 911, or go to the nearest emergency room.

Termination of Therapy

We reserve the right to terminate therapy at our discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, your needs are outside of your provider's scope of competence or practice, or you are not making adequate progress in therapy. You have the right to terminate therapy at your discretion. Upon either party's decision to terminate therapy, we will generally recommend that you participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. You will be offered 3 referrals to provide a continuum of care.

Acknowledgement

By signing below, you acknowledge that you have reviewed and fully understand the terms and conditions of this Agreement and have received a copy of NOTICE OF PRIVACY PRACTICES. You have discussed such terms and conditions with your provider, and had any questions with regard to its terms and conditions answered to your satisfaction. You agree to abide by the terms and conditions of this agreement and consent to participate in psychotherapy with your therapist. Moreover, you agree to hold your therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____

Patient Name (please print)

Signature of Patient (if Patient is 12 or older) _____

Signature of Representative (and relationship to Patient)_____

Signature of Representative (and relationship to Patient)_____

Date_____

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

Name of Responsible Party (Please print)_____

Signature of Responsible Party (and relationship to Patient)_____

Date_____

Name of Responsible Party (Please print)_____

Signature of Responsible Party (and relationship to Patient)_____

Date_____