Danielle Reddel, M.S.

Licensed Marriage and Family Therapist
License # LMFT46234

Client Informed Consent for Treatment

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.

Information About Your Therapist

At an appropriate time, your therapist will discuss his/her professional background with you and provide you with information regarding his/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.

The individual therapist who operates this practice is:

Danielle Reddel, M.S., Licensed Marriage and Family Therapist
License Number LMFT46234

Fees

The fee for service is $100 per individual therapy session.
The fee for service is $100 per conjoint (marital /family) therapy session.
The fee for service is $30 per group therapy session.

Individual Sessions and conjoint (marital /family) sessions are approximately 50 minutes.

Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure. 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.

Health Insurance

Please inform your therapist if you wish to utilize health insurance/EAP to pay for services. If your therapist is a contracted provider for your insurance company, your therapist will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan.

You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage.

Although your therapist is happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided

to you. Please discuss any questions or concerns that you may have about this with your therapist.

Health Insurance Provider: _____

Member ID #: _____

Name of Insured: _____

Deductible: _____ Copay amount per session: _____

Number of Sessions allowed per year: _____

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 provide their written authorization to release.

Exceptions to confidentiality Therapists are required by law to report:

- suspected child, dependent adult or elder abuse
- serious danger of physical violence to another person
- if a client is a danger to him or herself

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 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.

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

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.

Your appointment day/time is reserved for you to meet with your therapist. In order to cancel or reschedule an appointment, please notify your therapist at least 24 hours in advance of your appointment. **If you do not provide your therapist with at least 24 hours' advance notice, you will be charged a $50 missed session fee.** Please understand that your insurance company will not pay for missed sessions.

Therapist Availability/Emergencies

As a general rule, important issues are better addressed within regularly scheduled sessions. If you need to contact your therapist between sessions, you may leave a message for your therapist at any time on her confidential voicemail or send an email or text**.

If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call.

If you have an urgent need to speak with your therapist, please indicate that fact in your message.

You should be aware that your therapist is generally available to return non-urgent phone calls, emails and texts within the next business day.

****Potential risks** The client understands that email and text messages are for the purposes of scheduling appointments and general communication. In signing this consent, you are acknowledging that email sent over the Internet is not secure and should not be used to communicate very confidential and/or health information directly. It may be accessed and viewed by other users without your knowledge while in transit and thus, its confidentiality cannot be guaranteed. If an email is sent from a patient with sensitive patient information, the patient will bear sole responsibility for any privacy related outcome of this communication, whether intended or not. In addition, e-mail or text communication may become part of the clinical record.

In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please immediately call 911 to request emergency assistance.

You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis:

OC Crisis/Suicide Prevention Hotline: (877) 727-4747 (24hr/7days)
Casa Youth Shelter: (800) 914-2272
Laura's House Domestic Violence Hotline: (866) 498-1511 (24hr/7days)
Mission Viejo Hospital: (949) 499-1311

Therapist Communications

Your therapist may need to communicate with you by telephone, email or text. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

Please Initial

Check preferred method for contact

( ) My therapist may call me on my home phone. _____

( ) My therapist may call me on my cell phone. _____

( ) My therapist may send a text message to my cell phone. _____

( ) My therapist may communicate with me by e-mail. _____

( ) My therapist may send mail to me at my home address. _____

Do not contact me (time/day) _____

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 recommendations to you regarding your treatment. It is important that therapists and patients be 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.

Your therapist will work with you to develop an effective treatment plan. Over the course of therapy, your therapist will attempt to evaluate whether the therapy provided is beneficial to you. Your feedback and input is an important part of this process. It is the goal of your therapist to assist you in effectively addressing your problems and concerns. However, 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.

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. 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 or Guardian Name (Please Print) Client or Guardian Signature

_____

Date