Denise C Williamson, Marriage & Family Therapy, Inc., License No. 82446
(805) 245-2012
1411 Marsh Street, S-201; San Luis Obispo, CA

Consent For Treatment

Client Name: _____DOB: _____

_____ DOB: _____

This Agreement is intended to provide:
_____
with important information regarding the practices, policies and procedures of Denise Williamson (Therapist). Any questions or concerns regarding the contents of this Agreement should be discussed with Denise Williamson prior to signing.

Confidentiality: You have the right to confidential treatment except under the following situations: 1) You disclose that you are abusing a child, elder, or dependent adult; 2) You or your family disclose your intent or plan to harm another person; 3) Therapist seeks consultation (no identifiers given); 4) If therapist believes you have serious intent or a plan to harm yourself, she is allowed to get you help; 5) Therapist receives a court order.

Fees/Financial Responsibility:
The usual and customary fee for service is $140 per 52–57-minute session for individual clients and $150 for couples, unless Denise Williamson has agreed to a sliding scale fee, or a rate as approved with an insurance company. Sessions longer than the agreed time are charged for the additional time pro-rata. There is an additional $20 fee for intake sessions. Therapist reserves the right to periodically adjust this fee. Patient will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payors, or by agreement with Denise Williamson.

The agreed upon fee between Therapist and Patient is $_____ for a 52-57 minute session. The Intake Fee is $_____. Therapist reserves the right to periodically adjust fee. Patient will be notified of any fee adjustment in advance.

From time-to-time, Denise Williamson may engage in telephone contact with Patient for purposes other than scheduling sessions**. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes.** In addition, from time-to-time, **Therapist may engage in telephone contact with third parties at Patient's request and with Patient's advance written authorization. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes.**

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Patients are expected to pay for services at the time services are rendered. Therapist accepts cash, checks, and major credit cards, including MasterCard, Visa, Discover and Insurance.

Patient is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payor. Patient is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles.

Crisis: Denise C Williamson, Marriage & Family Therapy, Inc. **does not** maintain a 24-hour crisis response. If you are in crisis, please call 911 or San Luis Obispo County 24-hour hot line at 211. After you have made calls to emergency personnel leave a message for Denise Williamson at (805) 245-2012. Any crises work performed in connection to your emergency will be billed at the regular rate. This includes but is not limited to, telephone calls, generating reports, or making arrangements with emergency personnel or hospitals.

Contact Between Sessions: Again, Denise Williamson does not maintain a crisis line. Refer to the above crisis information. Her office is equipped with a confidential voice mail system that allows Patient to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), however, cannot guarantee the calls will be returned immediately.

Contact by Email: Contact by email is for **appointment scheduling only.** Although Denise Williamson will continue to do her best to keep information confidential, electronic devices cannot be guaranteed. Absolutely **no crisis information** should be sent by email (refer to Crisis information above).

Cancellations: 24-Hour Notice is required for cancellation of a scheduled appointment. Failure to give 24-Hour notice will result in a bill of $40 for 1st missed session and your full fee for any future session cancellations within the 24-Hour period. Illness exceptions will be evaluated on a case-by-case basis. Insurance companies CANNOT be billed for no-show and missed appointments.

Results Can Not Be Guaranteed: Participating in therapy may offer a number of benefits to you including, but not limited to, a better understanding of your goals, values, improved relationships, or addressing other specific concerns that brought you to therapy. Change can sometimes lead to discomfort, especially in the beginning of therapy. Participating in therapy may also include recalling unpleasant events, feeling and experiences, or evoke strong feelings of sadness, anger, fear, etc. Such benefits may also require substantial effort on the part of the client. Let Denise

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Williamson know if you start to feel uncomfortable. She will make efforts to support you through any such difficulties. Although it is impossible to guarantee results, together we can work towards achieving your goals.

Patient Litigation: Therapist will not voluntarily participate in any litigation, or custody disputes. Therapist has a policy of not communicating with Patient's Attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's legal matter. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving the Patient, Patient agrees to reimburse Denise Williamson for any time spent on preparation, travel, court appearances, or other costs incurred Denise Williamson will bill at her usual customary hourly rate of $140 per hour.

Psychotherapist-Patient Privilege: The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, Patient is the holder of the psychotherapist-patient privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by Patient or Patient's representative. Patient should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

Termination of Therapy: Therapist reserves the right to terminate therapy at her discretion. Reasons for termination can include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient's needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient 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. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient.

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Acknowledgement: By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed such terms and conditions with Denise Williamson, and has had any questions with regard to its terms and conditions answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Patient agrees to hold 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 (s) (please print)

_____ _____

Signature of Patient(s) (or authorized representative) **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(s) (please print)

_____ _____

Signature of Responsible Party **Date**

_____ _____

Signature of Responsible Party **Date**

_____