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**Patricia “Trish” Vernazza** **M.A. LMFT, ATR-BC**

Licensed Marriage Family Therapist #38682 Board Certified Art Therapist #03-066

www.trishv.com

2774 Jefferson Street • Carlsbad • CA • 92008

Mailing address: PO Box 4725, Oceanside, Ca 92052

Phone: (760) 439-8874 Fax: (760)434-4789 Email: info@trishv.com

**CONSENT FOR TREATMENT**

Welcome to therapy or counseling. Building a therapist-client relationship is dependent upon trust, openness, responsibility, and respect for each person’s dignity. This document contains important information about my professional services. Please carefully review and sign this form as confirmation that you understand and agree to the terms of this therapeutic relationship. Feel free to ask for clarification on any of the items.

**Psychological Services:** Psychotherapy is not easily described in a general statement. In general, my task is to facilitate your search for answers to questions that can aid in changes to your life in a positive way. By assisting you to seek solutions and change behavior patterns, your life may be more manageable and satisfying. The process and length of psychotherapy varies depending on the personalities of the therapist and the client and the particular problems that the client brings to sessions. I am happy to discuss your progress and its implications for treatment length at any time during the course of therapy.

**CONFIDENTIALITY AND MANDATED REPORTING:** It is my goal to provide a safe and supportive environment for people who are participating in therapeutic services. I respect your privacy – all sessions are confidential. All communication between client and therapist will remain confidential unless you request specific information to be discussed with outside parties (for example, family members, health care professionals, school staff, etc.,) Information about you is generally held in confidence by law.

My policy is never to release information outside of sessions without your consent. State law and various court rulings require me to make a report to the proper authorities in one or more of the following circumstances:

* *Suspected abuse, past or present, of a child currently under the age of 18 years.*
* *Suspected abuse of elders or dependent adults.*
* *Intention of serious and dangerous harm to self or others.*
* *When you waive your confidentiality. (For example, you waive your confidentiality when using your insurance company/EAP because the insurance company needs your information in order to pay the claim.)*
* *When you voluntarily use your mental or emotional state in legal proceedings.*
* *Following a court order. If I am ordered by the court to testify or release records.*
* *As requested by a court appointed attorney for a child involved in legal proceedings*

Additionally, if you are currently of have been recently under psychiatric and/or medical care, it may be necessary for me to consult with the treating physician for the purposes of diagnosis, treatment, and continuity of care. **This informed consent agreement includes your consent for me to consult with other health care professionals as needed. (Initial) \_\_\_\_\_\_**

Consent to consult with other health care professionals as needed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

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**Couples Therapy and Confidentiality:** If you are here for couples counseling, my policy is not to hold secrets between the both of you. If one of you tells a secret between sessions or in an individual session, then I will assume that you are telling it in order to get help disclosing it to your partner. **(Initial) \_\_\_\_\_\_\_\_**

* During the assessment and interview phase of counseling, both members of the partnership will determine mutual goals for therapy.
* Both members of the partnership will attend scheduled appointments. If one member cannot attend, then the appointment must be rescheduled to allow both members to attend. 24 hour notice of cancellation required to avoid late cancellation fee.
* When individual sessions take place with each member of the partnership, it is understood that in the event sensitive information (as listed below) is revealed that may interfere with the goals of therapy, the individual will be expected to disclose this ulterior threat to the relationship and/or understand that the information will be revealed in the course of any future couple counseling work. This includes:
  1. “Love” interest, affair, or emotional attachment to another, other than partner.
  2. Financial difficulties, debt, liabilities that may impact the partnership.
  3. Medical concerns such as sexually transmitted diseases.
  4. Legal problems such as court dates, DUI, etc.
  5. Chronic alcohol and/or substance abuse, gambling, etc.
  6. Any form or degree of physical contact during arguments of fights.

**Adolescents and Children:** Adolescents and children in individual therapy will be afforded confidential treatment. Because trust is an important therapeutic issue, parents will be provided with general progress information only, no other information will be given unless it is determined by the therapist to be in the child’s best interest to do so. It is also imperative that treatment of children not be terminated abruptly. **By signing the consent to treat a minor, you are agreeing to provide me with a minimum of thirty days notification of your intent to terminate your child’s treatment, and also to allow for at least two pre-termination sessions in order to adequately process the terminations with the child. (Initial) \_\_\_\_\_\_\_\_\_**

**Fees:** **Payment for services rendered is due in full at the time of service and will be collected at the beginning of therapy.** I recommend preparing your payment prior to your arrival so that your time is maximized. Special arrangements on an individual basis can be made if this cannot be made. The therapy session consists of a 50-minute session. In order for therapy to be effective, therapy needs to take place on a regular basis. The best results occur when appointments are consistently scheduled and regularly attended.

My standard fee is **$200.00**-**$400.00** per 50-minute session, unless modified by other arrangements. The standard fee will be charged on a prorated basis for report writing, attending meetings, telephone conversations longer than ten minutes or the time required to perform any service you request of me. The agreed upon fee is \_\_\_\_\_\_\_\_\_\_\_. **Client initial**\_\_\_\_\_\_\_

Telephone consultations with your or other persons designated by you will be billed at my hourly rate with a $20.00 minimum (brief phone calls regarding scheduling are excluded).

Preparing Reports will be billed at my hourly rate plus an administrative fee of **$200.00.**

I do accept some insurance policies, but for clients that are paying for sessions privately, you have the option to submit a bill to your insurance company to see if they will reimburse you. Please let me know if you would like me to provide you with a statement.

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Statement of Services that reflect unpaid balances will be mailed out on a minimum weekly basis and a maximum 4x a month. Each preparation and mailing will cost $20.00, which will be added to your statement.

In the instance that an unpaid balance accrues, it will be turned over to a collection agency.

You will be responsible for the original bill, service charges, postal charges, collection fees, telephone calls requesting payment and any legal costs (including legal consultation fees) that are incurred.

**Credit Card Policy:**  If you choose to use your credit card for payment of services you will be charged a $10.00 handling fee for each transaction $200.00 and under. $20.00 Handling fees for $250.00-$400.00 . You may will receive a notice through your email address from Propay on my behalf and you will have 5 business days to compete the transactions to bring your account current. **(Initial) \_\_\_\_\_\_\_\_**

**Bounced Check Policy:** There is an additional fee $35.00 fee for any check that is returned for Non-Sufficient Fund **(Initial) \_\_\_\_\_\_\_\_**

**Cancellations:** 24 hours notice is required if you need to cancel a session. Your 1st time cancellation fee will be $100.00, thereafter the full fee will be charged. If you are using your credit card, your credit card will be charged automatically.  *(Please note that Insurance companies do not pay for cancellation or no show fees, you are responsible.) (***Initial*) \_\_\_\_\_\_\_\_***

**Insurance:** It is recommended that you contact your insurance carrier to find our how much they pay for outpatient psychotherapy treatment. The amount of payment will depend on your policy. Most medical health insurance policies do cover at least part of the cost of outpatient psychotherapy. If you are utilizing Medi-cal, County, or Insurance Funds, third parties for the purpose of authorization for treatment, quality care management, and payment may review your medical record, which includes diagnosis, treatment, progress, clinical notes, and prognosis. As a courtesy service your insurance may be billed. However payment is required at the time of service. You will be required to pay all fees not covered or denied by your insurance. If your insurance requires copies of progress notes, for each individual session to complete payment to you or to me, you will charged $10 per progress note to be paid by you, in form of check or credit card payable to Trish Vernazza. In the even that your insurance rescinds authorization for previous treatment, you are required to make full payment for those services deemed by the insurance company. A copy of notification that I receive will be given to you.

⓪ I understand my insurance will not be billed by my therapist and payment is due when services are rendered. \_\_\_\_\_\_ (**Initial)**

⓪ I understand that payment is due when services are rendered and that a HICFA 1500 form will be given to me to file with my insurance company for reimbursement. \_\_\_\_\_\_ (**Initial)**

⓪ I understand that my insurance will be billed. However total payment is required at the time of service. The name of my insurance company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(**Initial**)

**Substance Use:** Sobriety during sessions is mandatory. Should any individual attend therapy in an intoxicated state, the session will be cancelled and payment will be required. This will also constitute a late canceled session and insurance will not be billed.

**EAP:** Your EAP has authorized \_\_\_\_\_\_\_\_\_ number of sessions. However, your EAP does not cover missed or late canceled sessions. Should you miss an appointment, or cancel with less than 24-hours notification, you will be billed my standard hourly rate.

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**Contacting Therapist:** My voicemail system is confidential. Please leave a message with your number, even if you think I already have it, and your call will be returned. I am able to return most calls daily or within 24 hours, but usually cannot provide emergency treatment. If you cannot reach me and you need to speak with someone immediately, please call the San Diego 24-hour hotline at 1-800-479-3339 or 911. If an emergency occurs during our work together (or in the future after termination) where Trish Vernazza becomes concerned about your personal safety, possibility of you injuring someone else or about you receiving psychiatric care, steps will be taken within the limits of the law to insure that you receive the proper medical treatment. Your emergency contact may be notified. **(Initial) \_\_\_\_\_\_**

**Contacting Client:** There are times I may want to send something to your home, email, or leave a message on your phone. Since these modes of communication aren’t always confidential please check and initial all the modes of communication that you prefer.

⓪ Snail mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initial\_\_\_\_\_\_\_\_\_\_ ⓪ email \_\_\_\_\_\_Initial ⓪ Home phone\_\_\_\_\_\_\_\_\_\_Initial ⓪ Cell phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initial ⓪ Work p\_\_\_\_\_\_\_\_\_ Initial

**Acknowledgment of preferred language**

Your preferred language to be used in the office and sessions of Trish Vernazza is **English**, unless other wise stated below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If you request another language you are authorizing that contact must be made through your insurance company to offer a qualified interpreter for sessions, provided by that insurance company. **(Initial) \_\_\_\_\_\_\_\_**

**Acknowledgment of Coordination of Care with Primary Care Physicians and Health Care Professionals.**

I understand a separate form for Coordination of Primary Care of Physicians and Release of information for Health Care Professionals has been provided to me. **(Initial) \_\_\_\_\_\_\_\_**

**Acknowledgment of Licensed Marriage Family Therapist Independent Contractor Status:**

This document is to advise you that your counselor is not an employee or agent of this office. Your signature below acknowledges that you understand that services received from your counselor may be received at any facility and that Trish Vernazza, Licensed Marriage Family Therapist #38682, Art-Therapist – BC #30-066. Is not responsible for the actions of the services provided by your counselor. All billing or other services performed on behalf of Trish Vernazza are done as an accommodation. **(Initial) \_\_\_\_\_\_\_\_**

**Acknowledgment of Receipt of Notice of Privacy Practices:** (Initial) \_\_\_\_\_\_\_\_\_

I acknowledge that Trish Vernazza, MFT has provided me with a copy of the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA) **Acknowledgment of Hippa Compliant Zoom Therapy:** I acknowledge that Trish Vernazza,LMFT has HIPPAA compliant version of the Zoom videoconferencing software which is quite reliable and private. You will need to ensure your own privacy in your choice of location for our meetings. You will also need to download the free app, and a fast internet connection will be helpful. In case of technological problems, we can shift to the use of a telephone.(Initial) \_\_\_\_\_\_\_

**I have read, agree with, and understand all of the terms, conditions and policies stated above. I agree to pay for all services provided, up until the time that therapy is completed**.

Print Client Name Client Signature Date

Print Client Name Client Signature Date

Consent to treat a minor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_

Relationship to minor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_