Informed Consent & Agreement for Psychotherapy Services

CONSENT FOR TREATMENT: I hereby agree that I am entering treatment, or that my minor age child is entering treatment, with Susan BaileyKadin, MA, LMFT, lic.19874. I authorize and request that my treating provider carry out mental health examinations, treatments, and/or diagnostic procedures which now or during the course of my care are advisable. I understand that the purposes of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable. I am encouraged to discuss with the therapist any questions/concerns about my treatment. I agree to the following terms and policies:

FINANCIAL TERMS: You are responsible for verifying and understanding the limits of your insurance coverage. You are responsible for obtaining prior authorization for treatment from your insurance carrier or Employee Assistance Program (EAP). Upon verification of EAP or Managed Care insurance coverage and policy limits, your insurance carrier will be billed for you, and I will be paid directly by the carrier. You will be responsible for any applicable deductible and co-payments. If you are not eligible at the time services are rendered, you are responsible for full payment based on my contract rate with your insurance. My Sliding Scale Private Fee is $100-120 per 50 minute session. Fees and co-payments are payable at the time services are rendered by check or cash unless a written agreement is made with me.

FREQUENCY OF SESSIONS: Sessions are typically 50 minutes, once a week. It is sometimes in the client's best interest to meet more frequently. This is decided on a case by case basis with the client's collaboration. If there is a need and I am available to extend a session to 75 minutes that will be decided in collaboration with the client(s) and the fee will be adjusted accordingly. Occasional phone sessions are an option at the same rate.

CANCELLATION/MISSED APPOINTMENTS POLICY: There is a 24 hour cancellation policy. A scheduled appointment means that time is reserved only for you. **Except in a true medical emergency or natural disaster, you (not your insurance company) will be charged for payment of the session, which is half the cost of a private fee session, $60.**

THERAPIST AVAILABILITY / EMERGENCIES: Please understand that as a solo outpatient practitioner, I am unable to personally provide continuous 24-hour crisis services. **In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance, go to the nearest emergency room, and/or call the Psychiatric Emergency Assessment Team at (805) 371-8375.** In other types of urgent situations call (805)546-3737 and follow the instructions to talk to a live person who will attempt to contact me. I will do my best to return your call within 24 hours, unless I have left an outgoing voicemail message that I am on vacation or unexpectedly called away. There is a pro-rated charge for telephone consultations exceeding ten minutes.

RELEASE OF INFORMATION: You authorize the release of information regarding your care to your health plan for the payment of claims, certifications/case management decisions, and other purposes related to the administration of benefits of your health plan. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries. In order to provide quality services, I often need to collaborate with other professionals, such as your physician, psychiatrist, past therapists, and/or other mental health professionals. You will be asked to complete a release of information authorizing these exchanges; in some cases I may not be able to provide services without this.

CONFIDENTIALITY: The information disclosed by you is generally confidential and will not be released to any third party without written authorization from you, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, situations where you pose a threat of serious harm to yourself or someone else; cases involving suspected child, elder or dependent adult abuse; cases in which I am court-ordered to testify or produce records; or admitted prenatal exposure to controlled substances that are potentially harmful. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

If you participate in marital or family therapy, I 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 such information. **However, it is important that you know that I utilize a "no secrets" policy when conducting family or marital/couples therapy.** This means that I do not keep secret information gathered in individual conversations (whether on the phone or in an individual session) if the information revealed in some way violates the integrity of the couples/family therapy (such as revealing an affair, substance problem, or intent to leave the relationship). Such information will need to be revealed to the other partner for therapy to effectively continue. Please feel free to ask me about my "no secrets" policy and how it may apply to you.

PATIENT LITIGATION: I will not voluntarily participate in any litigation or custody dispute in which you and another individual, or entity, are parties. I have a policy of not communicating with patients' attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in any patient's legal matter. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate for such services.

DELINQUENT ACCOUNTS: You understand that you are responsible for all charges incurred and that services must be paid in full at the time of each visit, unless other arrangements have been made in advance. Should your account become delinquent and it becomes necessary for the account to be referred for collection action, you agree to pay the actual balance due plus any collection expenses of 30-50% of any balances owing, and any attorney's fees.

By signing below, Client(s) acknowledge that client(s) have reviewed and fully understand the terms and conditions of this Agreement. Client(s) have discussed such terms and conditions with the therapist, and have had any questions with regard to its terms and conditions answered to Client(s)' satisfaction. Client(s) agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with the Therapist. Moreover, Client(s) agree 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.

_____	_____	_____
Client Name (please print)	Signature of Client	Date
_____	_____	_____
Client Name (please print)	Signature of Client	Date