AmyHamilton licensed marriage and family therapist 310.817.0203

4419 Van Nuys Boulevard • Suite 202 • Sherman Oaks, CA 91403
amyhamiltontherapy.com • amyhamiltonmft@gmail.com
License MFC #90278

# Office Policies and Consent for Treatment

Welcome to my office. I am a Licensed Marriage and Family Therapist. I am trained to provide psychotherapy to adults, adolescents and children, and am governed by various laws, regulations and ethical standards. The Code of Ethics in my profession requires that I make you aware of specific policies. If you have any questions after reading this form, please bring them to my attention.

**Participation in Treatment:** Your decision to begin psychotherapy should be based on an understanding of the nature and purpose of psychotherapy, the risks and benefits of treatment, and the available alternatives. Please feel free to ask me any questions about the psychotherapy process. Understand that effective results are best achieved by consistent attendance in therapy.

**Appointments and Cancellations:** Psychotherapy sessions are 50 minutes long unless otherwise arranged in advance. If you are late for an appointment, I will see you for the remainder of your reserved time. Since scheduling a session involves reserving a time specifically for you, a minimum of 24 hours notice is required for rescheduling or canceling an appointment. Please note that you will be charged the full fee for missed sessions without such notification.

**Payment for Service:** All fees paid for services shall be paid to **Amy Hamilton, LMFT**. Fees may be paid by cash or personal check. It is customary to pay for services at the time they are rendered unless other arrangements have been made. Therapist reserves the right to periodically adjust this fee. Client 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 Therapist. As of the date of this contract, the agreed upon fee between Therapist and Client is _____.

**Insurance Reimbursement:** The Client is responsible for payment of all charges at the time of service. You may check with your insurance company to determine whether therapy costs are covered and to what extent. Confidential information will not be revealed to a third party payer without your permission. Please note that most insurance carriers do not reimburse for missed or canceled sessions.

**Telephone Accessibility:** I check messages regularly throughout the day and return calls as soon as possible. In the case of a true life-threatening emergency, please dial 911 or go to a local emergency room immediately. I am available to speak with you between sessions as needed. In the event that a lengthy telephone contact is required, you will be charged a full or pro-rated session rate.

**Safety:** To meet the professional standard of care, psychotherapists are expected to take reasonable steps to prevent suicide, and to attempt to ensure safety with the least possible violation of the Client's privacy and self-determination. If a Client makes a serious threat of physical violence to an identifiable victim, Therapist is required by law to notify the police and the intended victim. If Therapist has reason to suspect that a child, elderly adult or dependent adult is being abused or neglected, Therapist is mandated by law to make a report to the appropriate agency.

**Confidentiality:** The information that you share with me during your therapy session is strictly confidential. This means that I will not release any information about you, including the fact that you are a Client, without your prior written consent. If a reason to share information with another party arises, you will be asked to sign a form authorizing me to do so. You may revoke this authorization at any time by written notice.

**Confidentiality of Minors:** The parent of a minor has a legal right to access information about his child's treatment, unless otherwise stated by law. However, in order to facilitate effective treatment, this right must be balanced with the minor's right to a confidential therapeutic relationship. The confidences of minors will be respected as deemed clinically appropriate, though safety concerns will take precedence over confidentiality when the two conflict.

**Electronic E-Mail Contact and/or Skype Sessions:** You are welcome to communicate with me via e-mail for any appointment requests and/or cancellations. However, if I am required to read any lengthy correspondence or other communication, or asked to provide any written reports or letters, these will be charged at a pro-rated fee. In addition, all Skype sessions will be billed at my regular fee.

**Professional Conduct:** It is the Therapist's responsibility to avoid intentional or reckless harm to the client and to maintain appropriate boundaries. Sexual contact with a client is both a civil and criminal offense and should be reported to the California State Board of Behavioral Sciences.

**Termination of Services:** Participation in psychotherapy is strictly voluntary, and you may end treatment at any time you choose. The Client's professional relationship with the Therapist continues as long as the Therapist is providing professional services, and until either the Client informs the Therapist that he or she wishes to terminate therapy, or the Therapist notifies the Client that therapy is being terminated. Assistance in making appropriate arrangements for continuation of services will be provided when necessary.

**I have read and understand these policies.**

_____

Client Printed Name

_____

Client Signature Date

# Client Information

Name _____

Age _____ Date of Birth _____

Address _____

_____

Email:_____

Phone: (H)_____ (W)_____ (C)_____

Please circle the number or numbers where you prefer to be contacted.

**Current Relationship Status:**

❏ Married ❏ Cohabitating ❏ Life Partner ❏ Single ❏ Divorced ❏ Widowed

❏ Other_____

How long in current relationship?_____

**Others family members living with you:**

| Name | Relationship | Age |
|---|---|---|
| Name | Relationship | Age |
| Name | Relationship | Age |
| Name | Relationship | Age |

Your Education_____

Your Occupation_____

Emergency Contact_____

Name Phone

_____

Relationship to you

**Your Consent to Participate in Psychotherapy**

_____

Client Name (Print) Date

_____

Client Signature