

Agreement for Service / Informed Consent

Before we begin our work together, I would like you to be aware of the following information and to discuss any questions you may have.

Therapist Background and Qualifications

I have been practicing as a licensed marriage and family therapist (LMFT) since 1993, working with individuals, couples, parents/families, adolescents, incest survivors, persons with depression and life transition issues. My theoretical orientation can be described as eclectic with an emphasis on neuroscience and mindfulness techniques, incorporating an understanding of the mind and brain into therapy. I am a Clinical Member of, and practice according with the ethical standards of the California Association of Marriage and Family Therapists.

Policy Regarding Consent for Treatment of a Minor Child

I generally require the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of Representative to give consent for psychotherapy, I will require that Representative submit supporting legal documentation, such as a custody order, prior to the commencement of services.

Appointments

Sessions run 50 minutes long. This is your time, so plan to arrive on time. **If you need to cancel your appointment, you must do so at least 24 hours in advance, or you will be responsible for the full session fee.** Please provide longer advance notice whenever possible.

Availability between Sessions

A 24-hour Voicemail is available at (408) 262-6837. In the event that I cannot be reached quickly, you may consider calling Santa Clara County's mental health center at either (408) 299-6234 or (408) 279-3312. Phone contact that is not occasional and is not limited within a 10 minute window will be prorated at your regular hourly rate. Phone sessions can be arranged by request. When I am out of town, I will make arrangements for another therapist to cover crisis calls.

Confidentiality

Everything you share during our sessions is confidential, and will not be communicated to others except under the following circumstances:

- When you have given written consent.
- When required by law: If you threaten to harm yourself or someone else, I am legally required to take whatever actions necessary to protect any identified person from harm, including notifying the police. If I have reason to believe that abuse or neglect of a child, elder, or dependent adult has occurred, I am legally required to report this to the appropriate agency. The courts have, in some instances, permitted the use of subpoenas to gain access to a client's records. I will respond to all subpoenas, but will refuse to release record unless ordered to by a judge. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Patient agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made herself available for such an appearance at Therapist's usual and customary hourly rate of \$300.
- When required by your insurance or managed care organization to verify symptoms, diagnosis, and treatment, provided you have signed a release.
- When required for effective treatment, i.e. sharing of anonymous information for consultation purposes.

For Your Protection

Business and social relationships between therapist and clients, outside of the therapy setting, are unethical and unacceptable. Sexual relationships between the therapist and client, under any circumstances, are unethical, unacceptable and illegal.

Fee and Fee Arrangements

Please make checks payable to "Patt Saso." I prefer to take care of payment, scheduling appointments, and any other practical matters at the beginning of the session, so that you may leave the session with your feelings and experience without having to interrupt the process to handle these practical items. I accept cash, checks, and major credit cards MC and Visa.

The usual and customary fee for service is \$125 per 50-minute session. Sessions longer than 50-minutes are charged for the additional time pro rata. I reserve the right to periodically adjust this fee. You will be notified of any fee adjustment in advance. Patients are expected to pay for services at the time services are rendered.

Insurance

I do not work with or sit on a panel for any insurance company, managed care organization, or any other third-party payor. You pay for services at the time services are rendered. If you request I can fill out a "Superbill" to send to your insurance company or medical reimbursement plan.

Insurance companies or medical reimbursement plans require that a diagnosis be provided in order for the claim to be processed. If you have concerns about your diagnosis please feel free to discuss these with me.

Risks and Benefits of Therapy

A minor patient will benefit most from our work together when his/her parents, guardians or other caregivers are supportive of the therapeutic process. Psychotherapy is a process in which Therapist and Patient, and sometimes other family members, discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so that your child can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties s/he may be experiencing. Psychotherapy is a joint effort between Patient and Therapist.

Our work together is an important choice in your child's life. It requires a commitment of time, energy, and money. I welcome your questions about my work to help you make the best choice to support your child's needs.

Termination of Therapy

When the time comes to end our work together, I request a minimum of two closing sessions, in order to bring a conscious closure to your therapeutic process.

Acknowledgement

I/We, the undersigned, have read and understood this disclosure statement regarding the therapeutic relationship.

Patient Name (please print) _____

Signature of Patient _____ **Date** _____
(if Patient is 12 or older)

Signature of Mother _____ **Date** _____
(or Representative and relationship to Patient)

Signature of Father _____ **Date** _____
(or Representative and relationship to Patient)