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**WELCOME TO MY OFFICE: The following document is designed to give you information about my professional services and business policies. Please read this carefully. If you have any questions or concerns, please ask me at your first session, or as they arise during the course of treatment. Please note that when you sign this form, it represents an agreement between us.**

## AGREEMENT FOR SERVICE / INFORMED CONSENT

### **Introduction**

This Agreement is intended to provide \_\_\_\_\_ (herein "Patient") information regarding the practices, policies and procedures of Gloria Sanchez-Perez, LMFT (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Therapist has been practicing as a licensed marriage and family therapist (LMFT) for 7 years, working mostly with individuals, couples and minors. Therapist's theoretical orientation can be described as cognitive behavioral and family systems.

Our first few sessions will involve an evaluation of you needs. Patient should address any concerns s/he has regarding progress in therapy with Therapist. During this initial period I want you to evaluate your comfort level with me as your therapist and address any questions you have about the process.

### **Risks and Benefits of Therapy**

Psychotherapy is a process in which Therapist and Patient discuss a myriad of issues, events, experiences and memories so Patient 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 Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed as well as many other factors.

Participating in therapy may result in a number of benefits to Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy and responsibility, and increased self-confidence.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Patient's perceptions and assumptions, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationships is the responsibility of Patient. There are no guarantees about what you will experience, or when or how fast you will feel improved.

**Please initial here that you have read and understood Page 1:** \_\_\_\_\_

### **Confidentiality**

The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another. In certain legal situations, such as in a child custody case or when your emotional condition is an issue (for example, in a Worker's Compensation or personal injury case), the judge may order me to testify. In the event that an account with me goes unpaid, it is legal for me to disclose your name, dates of sessions, and amount due to a collection agency, or small claims court as necessary.

I practice in an office with other mental health professionals and I may employ administrative staff, I may need to share protected information with these individuals for both clinical needs and administrative purposes, or in the event I have an emergency and another clinician needs to contact you to notify you of a cancelled appointment. All mental health professionals are bound by the same rules of confidentiality. All members have been given training about protecting your privacy and have agreed not to release confidential information outside of my practice without appropriate Authorization for Disclosure, or one of the above listed mandates and/or emergencies.

Federal Law under the Patriot Act states that when the federal government believes an individual to be a threat to national security, the government may access an individual's therapy records with a federal warrant. In the unlikely event that this occurs, the therapist will not disclose to Patient that this event has happened.

Therapist is obliged to report instances where a patient states that h/she has downloaded, streamed, or accessed through any electronic or digital media depictions in which a child is engaged in an act of obscene sexual contact.

#### **Confidentiality with Family and Couples Therapy**

When working with family members and couples, I ask all parties to sign releases of information so that I may share relevant information and give important feedback to all those participating in treatment. In situations where *one* family member or *one* partner requests that I release information about the family or couple's sessions, it is my policy not to release information unless all family members (or both members of the couple) sign an authorization allowing me to do so.

#### **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, the 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 s/he might be waiving the psychotherapist-patient privilege if s/he makes mental or emotional state an issue in a legal proceeding. Patient should address any concerns s/he might have regarding the psychotherapist-patient privilege with his/her attorney. There are however exceptions to privilege, which includes, but is not limited to: 1) a patient is a danger to self or others, 2) a judge issues a court order, 3) a patient introduces his/her mental condition into testimony, 4) someone is under 16 and victim of crime, 5) the court is using therapy to establish sanity or competence to stand trial, 6) a patient has treated information as though it is not confidential, 7) information pertaining to the Patriot Act, 8) information pertaining to on-line, electronic, digital media child pornography, 9) information listed on a health insurance claim form or child abuse report, 10) a patient files a complaint or lawsuit against me.

#### **Professional Consultation**

Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personal identifying information regarding Patient. For

professional consultations with people with whom you have asked or allowed me to speak (physicians, attorneys, schoolteachers, therapists, etc.), I charge in quarter-hour segments (for calls that are more than fifteen minutes). I also charge for time writing letters/reports about your case or reading reports. I will notify you about these charges before beginning these activities. These are charges that insurance companies usually do not cover. If you become involved in legal proceedings that may require my participation, you will be expected to pay for my professional time even if I am called to testify by another party.

Clinical records are maintained in secure confidential matter during treatment and for up to ten years following the termination of treatment. After ten years clinical records will be destroyed in a confidential manner and cannot be accessed. If within the ten years following treatment, for any reason I am no longer in practice, or upon my death, I will designate another mental health professional to continue to securely keep and maintain my records and you will be notified of that therapist's name just in case you have the need to access records at a later time.

### **Records and Record Keeping**

Therapist may take notes during session, and will also produce other notes and records regarding Patient treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter the normal record keeping process at the request of Patient. Should Patient request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as request, provide a copy of the record to another treating health care provider.

### **Patient Rights**

HIPAA provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized, determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures in your records; and the right to a paper copy of the agreement, the attached notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

### **Minors and Parents**

Patients under 18 years of age who are not emancipated generally require parental consent in order to begin treatment. Parental consent must come from a parent or guardian with legal custody. If your minor is the subject of a divorced union it is appropriate to bring a copy of your most recent custody agreement in order to initiate consent for treatment. In most cases, both parent signatures are required to commence treatment.

**Please initial here that you have read and understand Pages 2 and 3:** \_\_\_\_\_

### **Patient Litigation**

Therapist *will not voluntarily* participate in any litigation, or custody dispute in which Patient and another individual, or entity, are parties. Therapist has a policy of not communicating with Patient's attorney and will generally not write or sign letters, report, declarations, or affidavits to be used in Patient's legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist 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 \$100.00 per hour. Fees must be paid in advance and are not reimbursed by medical insurance.

### **Fee and Fee Arrangements**

The usual and customary fee for service is \$100.00 per 50 minute individual session and \$120.00 per family/couple session. Sessions longer than 50/60 minutes are charged for the additional time pro rata. 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 payers, or by agreement with Therapist.

From time to time, Therapist 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. Patients are expected to pay for services at the time services are rendered. Therapist accepts cash, checks and credit cards (Visa and MasterCard).

### **Missed Sessions and Cancellation Policy**

If you are late, your appointment will still have to end on time for the courtesy of my next client and the fee remains the same because your fee is based on the amount of time reserved, not the amount used. Insurance will generally not pay for a missed session and if you miss a session or cancel late your insurance company will not help you cover the fee for that session. If you have a set session time and you fail to show up or cancel in advance for three consecutive weeks, I will assume you are no longer interested in that time slot and make it available to other clients. Patient is responsible for payment of \$60.00 for any missed session(s), and if Patient fails to give Therapist at least 24 hours notice of cancellation. Cancellation notice should be left on Therapist's voice mail at (909 989-5556, ext.7).

### **Insurance**

In order to use your medical insurance benefits, information must be conveyed to your insurance company. My contract with insurance carriers generally requires me to provide any information the insurance company needs in order to process your mental health claims. This information includes, but is not limited to, your identifying information, name, current address, birth-date, insurance ID number, marital status, dates of sessions, type of psychotherapy, amount due, and diagnosis. The diagnosis helps the insurance company know what symptoms you may be experiencing. This can include, in some instances, full access to your records. Before disclosing this information, the insurance company is required to provide written notification stating what information is being requested, why they are requesting it, how long it will be kept and what will be done with the information. In such instances I will make every effort to release only the minimum information that is necessary for the purpose. I will

### **Please initial here that you have read and understand Page 4:** \_\_\_\_\_

let you know your insurance carrier is requiring more than the standard claim form for payment. Though all insurance companies claim to keep such information confidential, I have no control over what they do once it is in their hands. If you are uncomfortable with your insurance company having any mental health information about you, you can decide to pay the fee yourself and leave the insurance carrier out of the equation.

My biller will complete insurance forms on your behalf and bill your insurance company directly. If you have a co-payment, I will ask you to pay it at each session. Please note that your insurance policy is a contract between you and your insurance company. Although your insurance company will be billed for fees, you are responsible for that

portion of the fee that is not reimbursed by your insurance company (e.g., deductibles, copayments, cancelled sessions, etc.). If your insurance company pays only a portion of the bill or rejects it entirely, the insurance company will send an explanation of benefits to you. Reduction or rejection of your claim does not relieve you of your financial responsibility for your therapy sessions. If unusual circumstances of financial hardship develop, please let me know so that we may discuss possible payment options. If your check “bounces” and is returned by the bank for insufficient funds, you are responsible for making payment in full and for any bank fees. You will be asked to sign an authorization to release information to your insurance/managed care company which permits me to release information about you that is necessary to process claims and request additional sessions. If you have any questions or concerns about disclosure of information to your manage care/insurance company, please discuss them with me.

### **Therapist Availability**

Therapist’s office is equipped with a confidential voicemail system that allows Patient to leave messages at any time. Therapist will make every effort to return calls within 24 hours (or by the next day Therapist is in the office), but cannot guarantee calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, s/he should call 911, or go to the nearest emergency room.

E-mailing should be considered carefully because I cannot guarantee the confidentiality of the Internet or your work/home computer. I do not respond to e-mails/texts for this reason and prefer to discuss e-mails/texts in session. Do not leave appointment changes on the Internet. Voicemails are a more effective way to reach me.

### **Termination of Therapy**

Therapist reserves the right to terminate therapy at her discretion. Reasons for termination include, but are not limited to, untimely payment for fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient 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.

**Please initial here that you have read and understand Page 5**

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### **Acknowledgement**

By signing below, Patient acknowledges that s/he has reviewed and fully understands the terms and conditions of this of this Agreement. Patient has discussed such terms and conditions with Therapist, 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.

x \_\_\_\_\_

**Patient Name (Please Print)**

x \_\_\_\_\_

**Signature of Patient (or authorized representative)**

x \_\_\_\_\_

**Date**

x \_\_\_\_\_

**Signature of Patient (or authorized representative)**

x \_\_\_\_\_

**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 payer

x \_\_\_\_\_

**Name of Responsible Party (Please Print)**

x \_\_\_\_\_

**Signature of Responsible Party**

x \_\_\_\_\_

**Date**

x \_\_\_\_\_

**Signature of Patient (or authorized representative)**

x \_\_\_\_\_

**Date**