Form # 3 **Disclosure Agreement**

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Disclosure Statement & Agreement For Services

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

Information about Your Therapist

At an appropriate time, your therapist will discuss his/her professional background with you and provide you with information regarding his/her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience and professional orientation.

Your therapist is a: **Licensed Marriage and Family Therapist**

Name License Type & License Number : Nita Prasad, L**MFT 43500**

Fees and Payment Policy: The full fee for service is **$180.00** per individual and conjoint (marital /family) therapy session. Individual Sessions and conjoint (marital /family) sessions are approximately **45-50 minutes** in length. Your therapist occasionally will provide service on sliding scale. Fee is discussed before service begins. Sliding scale is based on income and number of therapy sessions in a week. **There is also a charge for any written documents requested by you for personal and/or legal purposes like court and also for telephone consultations with any other providers at $180 and for court or legal purposes at the rate of $250. These are billed at 10 minute increments. Please note services such as any court mandated or recommended individual or family therapy, reunification or supervised visitation therapy or recommendations and reports for courts and others are not covered by your insurance, hence will be billed to you directly.** Occasionally there will be fee increases. Fees are payable in full at the time that services are rendered. Your therapist accepts check or cash, paypal only. No credit cards.

Please inform your therapist about method of payment for services. **Your provider only accepts LYRA insurances**. **Please circle & initial one of the following: Self Pay ( )**

INFORMED CONSENT

If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

Your therapist accepts paypal or check only, NO credit cards. However, if the check is returned due to insufficient funds or incorrect account information, you are responsible for all charges incurred on your account as well as the therapist's.

You are also responsible for any fees incurred by the therapist for time or expenses incurred filing any **legal or small claims courts claims** or using a **collections agency** for lack of payment of services rendered which includes full **payment of $180.00 or the therapy session negotiated amount for No shows and less than 48 hours cancellation. Please note, when any collection agency or court is involved, your confidentiality is compromised. Unpaid debt is also reported to agencies including but not limited to, Credit Bureaus and Credit reporting agencies/businesses.**

Please initial here to indicate understanding & acceptance of insurance & payment policy: _____(Client Initials)

Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission or it is court ordered, to release information about your treatment. If you participate in couple or family therapy, your therapist does not withhold information from any of the participating family members and abides with no- secrets policy. This means that if you participate in family and/or couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him/her, when working with other members of your family.

Please check with your therapist about how this applies to your situation.

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse and when it's determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. Under these situations, your therapist is a mandated reporter and has to inform the local authorities about these situations to ensure safety for the persons. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act

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There is **no confidentiality rule** applied when therapy is court ordered, for Therapeutic Visitation and Family Reunification or when ordered/mandated by one's manager/employer and any other Social Service Agency.

Please note, in such cases, the process is **NOT** confidential and the therapist is obligated to report back to the one Mandating the therapy.

Your confidentiality is also compromised in case of unpaid debts owed to your therapist. Please see above mentioned Section for payment policy.

_____(Client Initials)

INFORMED CONSENT Therapist Communications: I communicate with clients via email or phone number, including sending out text reminders only for appointments, so please indicate the number you prefer me to call and send text reminders. Also, by agreeing to giving your number, you are allowing me to text you appointment reminders

(_____)_____ **(Client Phone number)**

_____ **(Client Initials**

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day, if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 48 **business/weekday hours** in advance of your appointment. If you do not provide your therapist with at least 48 business hour notice in advance, you are responsible for the full payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions. You will be billed at the full fee rate of **$180 or the therapy hour negotiated amount** for No Shows and cancellation less than **48 (weekday/ business hours)** hours notice. Holidays and weekends are not included as weekdays.

_____(Client Initials).

Therapist Availability/Emergencies

Telephone consultations between weekly sessions are welcome. However, your therapist will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions. **The charge for phone consultations and voicemails, is in increments of 10 minutes, based on hourly rate of $180 per hour or the sliding scale fee.** This is not covered by your insurance, and will be billed directly to you. **_____ (Client Initials)**

You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during my normal workdays (Friday- Sunday) within 48 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your email, text, or phone call and follow any instructions that are provided by your therapist's voicemail.

You should be aware that your therapist is generally available to return phone calls within **approximately 48 hours.** Your therapist is not able to return phone calls after **9:00** PM. on weekdays. Your therapist is also not available to return phone calls on vacations, holidays.

Please write the **name and number of an Emergency Contact person** you give your therapist permission to contact in case of an emergency:

Name & Phone Number:_____

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.

You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis:

Crisis Hotline: (800) 309-2131

Youth Crisis: (800) 448-4663

Domestic Violence Help: (510) 794-6055

Alameda County Child Protective Services: (510) 259-1800

_____(Client Initials)

INFORMED CONSENT: About the Therapy Process-It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. Therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress & will invite your participation in the discussion. Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result. In court and employer mandated therapy, the therapeutic goals are pre-set by those requesting the therapy.

_____ (Client Initials)

Disclosure Agreement Form # 3

Written Reports/Summary of Treatment/Court Appearances

Your therapist charges an initial **$1000 for showing up at court** for the following but not limited to, depositions or as an expert witness, and then an additional hourly rate of **$500** per hour, billed in increments of 10 minutes, for any requests of written reports or summaries of treatment with me or if your therapist is subpoenaed to appear in court on your behalf, any depositions at any location, including time spent waiting for above mentioned activities.

If you want a **written or verbal summary** of your treatment, for yourself or any other provider and/or agency/ court, to further assist with your treatment, please be advised your therapist charges a flat rate of **$250** per **one page document and charges for verbal summary in increments of 10 minutes**, not including any additional time spent gathering information, printing and mailing fees involved.

Please be advised, any court and/or agency involvement will compromise your confidentiality and the therapist is no longer responsible for any liability that arises out of any court and/or agency involvement.

_____(Client Initials)

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Your signature indicates that you have read this agreement for services carefully and understand its contents. Please ask your therapist to address any questions or concerns that you have about this information before you sign.

_____ Signature	_____ Relationship to Client	_____/___/___/_____ Date
_____ Signature	_____ Relationship to Client	_____/___/___/_____ Date
_____ Signature	_____ Relationship to Client	____/____/___/_____ Date

Please make a copy of the signed form for your records before submitting to your therapist.

TELEHEALTH CONSENT FORM

I, _____(Patient) hereby consent to engage in Telehealth with **Nita Prasad, LMFT Lic. #43500** (Therapist).

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the [Informed Consent Form or Statement of Disclosures] I received from my therapist also apply to my Telehealth services.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and my therapist may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.
6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.
7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.
9. I have discussed the fees charged for Telehealth with my therapist and agree to them [or for insurance patients: I have discussed with my therapist and agree that my therapist will bill my insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g. co-payments)], and I have been provided with this information in the [Informed Consent Form or Name of Payment Agreement Form].
10. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist

may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

11. I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

[For conjoint/ family therapy, patients may sign individual consent forms or sign the same form.]

_____
Patient's Signature Date

_____
Patient's Printed Name

Verbal Consent Obtained

Therapist reviewed Telehealth Consent Form with Patient, Patient understands and agrees to the above advisements, and Patient has verbally consented to receiving psychotherapy services from Therapist via Telehealth.

_____
Therapists Signature Date