Healing from the Past,
Help for the Present,
Hope for the Future

Darcy R. Greene MA, LMFT (MFC# 53395)
Crossroads Counseling
Licensed Marriage Family Therapist

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Contract for Psychotherapeutic Services

Consent for Treatment Form

The following information describes the operating procedures of Darcy Greene's practice. Please read it over carefully. If you have any questions, I will be happy to answer them. Please keep a copy of this form for future reference. Additional copies are available through the website (DarcyGreene.org).

I. The Therapy Process

Participating in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that lead you to seek therapy. Working toward these benefits, however, requires effort on your part and may result in your experiencing considerable discomfort. Change will sometimes be easy and swift, but more often it will be slow and frustrating. Remembering unpleasant events and resolving them through therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended. When working with children, behavioral symptoms often increase before positive changes occur. As part of the therapeutic process, I may use several techniques including art, role-play and homework assignments.

II. Client's Rights

You have the right to a confidential therapeutic relationship. Within certain legal limits (see Limits of Confidentiality), information revealed by you during the course of therapy will be kept completely confidential and will not be revealed to any person without your written permission.

1. You have the right to know the content of your records at any time and I have the right to provide you with the complete records or a summary of their content.
2. With your written consent, I can release any part of your records on file to any person you specify. Upon making your request I will inform you whether or not releasing that information to that agency or person might be harmful to you.

4. Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding you or your family members or caregivers.
5. You have the right to ask questions about any of the procedures used in the course of your therapy. I will explain my customary approach and methods to you.
6. You have the right to choose NOT to receive therapy from me. If you choose this, I will provide you with names of other qualified professionals whose services you might prefer.
7. You have the right to terminate therapy at any time without any financial, legal, or moral obligations other than those you've already incurred.
8. I have the right to terminate therapy with you under the following conditions:

    A. When I believe that therapy is no longer effective.

    B. I believe that you will be better served by another professional, whom I will recommend. If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified. If I have written consent from you, I will provide that professional with the essential information he or she requires.

    C. When you have not paid for the last two sessions, unless special arrangements have been made.

    D. When you have failed to show up for your last two therapy sessions without a 48-hour notice.

    E. When you have not attended a session in four weeks.

III. Exceptions to Confidentiality:

As a licensed therapist there are certain legally defined situations which require me to reveal information you have told me during the course of therapy. I am not required to inform you of my actions if this occurs. It is very important that you and those seeking counseling with you carefully read and understand the following limits to confidentiality:

1. If you reveal information about active child abuse or neglect, elder abuse, or dependent physical abuse, I must make a report to protective services. When a perpetrator of child abuse is in contact with minors and there is a reasonable suspicion that he/she may still be abusing minors, I must also report that information.
2. If you seriously threaten harm or death to another person, I am required to warn the intended victim and notify the appropriate law enforcement agencies.
3. If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in that subpoena.
4. If you are in a lawsuit where emotional harm is being claimed, the opposing side may subpoena your therapy records.
5. The State Law in Evidence Code 1018 reads that "There is no privilege (confidentiality) under this article if the service of the psychotherapist were sought or obtained to enable or aid anyone to commit or plan to commit a crime or a tort or to escape detection or apprehension after the commission of a crime or a tort." (Evidence code 1024, *1965.* Chp. 299)

III. Fees

I agree to pay the standard fee of $ 125.00 for each completed 50-minute session (prorated for longer sessions). I will make payment in cash, check or credit card/atm at the time of the therapy appointment, unless we have made other arrangements in advance. I understand I can leave therapy at any time. I am contracting only to pay for the completed therapy sessions, sessions I miss without providing 48 hour notice and telephone time as outlined in Part V of this contract.

IV. Office Policies

Payment for Services: You are expected to pay for services at the time they are rendered unless other arrangements have been made. Please notify me if any problem arises regarding your ability to make timely payment. Unfortunately I cannot allow clients to run a bill with me nor I can I accept barter for therapy. Any overdue bills will be charged 1.5% per month interest. If you eventually refuse to pay your debt, I reserve the right to give your name and the amount due to a collection agency. There is a $30.00 charge for each returned check.

Appointment Times: You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for 50 minutes. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than forty-eight hours notice, you must pay for that session at our next regularly scheduled meeting. The answering machine has a time and date stamp which will keep track of the time that you called me to cancel. Because I cannot bill insurance for missed sessions you are responsible for the full cost of any missed sessions.

If you do not attend your scheduled appointment and do not notify me of your absence in advance I may choose to make the space available to another individual. If you no-show for two sessions in a row I will assume you have dropped out of therapy.

Insurance Reimbursement & 3rd Party Payers: Unless previously agreed upon, clients who carry insurance will bill their own insurance. I typically do not bill insurance companies nor do I accept payment from them unless I am an approved provider under your plan. (There are a few exceptions). Clients who want to utilize their insurance are HIGHLY encouraged to fill out the Insurance Eligibility form before the first visit. This will allow my office to verify coverage before you begin treatment. *Insurance billing is done as a courtesy to you; It is your responsibility to stay current with your insurance, including alerting me if you become uninsured or if your deductible needs to be met. You agree to pay all co-payments as required by your insurance and any money owed which they do not pay.* Your insurance/3rd party payer may request certain information and you agree to provide or consent to my providing the information they request. In the event they fail to pay you are financially responsible for your bill.

Cancellation: Since an appointment reserves time specifically for you, a minimum of 48 hours' notice is required for rescheduling or cancellation of an appointment. The full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed appointments.

Office Hours: My business hours are from 12 noon to 8:00 pm Monday to Thursday. If you need to contact me between sessions, please leave a message and I will return your call.

Time Telephone: After 5 minutes of telephone time, you will be charged at your regular fee, calculated in 10 minute increments.

Sessions Greater than 50 minutes: Sessions that go beyond 50 minutes will be prorated to the nearest quarter hour, unless you have made prior arrangements with me.

Emergency Procedure: An emergency is an unexpected event that requires immediate attention and can be a threat to your health. If an emergency situation arises, please state this when you leave your message. I or a clinical staff member will call as soon as possible. If I have not called you back within 60 minutes, the emergency persists, and the emergency requires it, please call 911, your physician or admit yourself to a hospital for observation.

Email Usage: By nature, therapy is confidential. You can have the confidence that your insights, vulnerable experiences, and feelings will not be repeated outside the therapeutic relationship established. **By nature, email correspondence is NOT confidential.** Though Internet security measures can be effective, it is never 100% foolproof. My policy regarding email usage is as follows:

1. Email correspondence with me is NOT secure.
2. Email and text communication is for non-emergencies only. It may be used for appointment changes, referrals, and non-clinical questions.
3. Email correspondence is NOT a substitute for person-to-person therapeutic treatment, unless discussed with me in advance and in person.
4. Email correspondence will not play a part in your therapy.
5. Generally I will not respond to your emails. Anything stated in an email from you will be discussed in session, and in session only.
6. Email correspondence is NOT to be used in the case of an emergency to contact me.

Childcare: No child or teenager may be left unattended in the waiting areas without an adult present to watch them while you are in your counseling sessions.

Reports & Collateral Contacts: Sometimes I am asked to make phone contact and/or write reports to send to schools, out-of-state parents, physicians, insurance companies and so forth. You will be charged according to the time spent on each report requested. Insurance plans typically do not reimburse you for these charges. You will not be charged for brief summaries for insurance companies.

Litigation and Contact with Third Parties Limitation: I will not voluntarily participate with clients' litigation, custody dispute or other dealings with third parties. This means that I do not interact with my client's attorneys and generally do not write or sign letters, reports, declarations of affidavits to be used in Patient's or Representative's legal matter. (Such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.) Generally I will not provide records or testimony unless compelled to do so. In the event of any legal proceedings, you agree that neither you, nor your attorney, nor anyone else acting on your behalf will call me to testify in court or any other proceedings; nor will a disclosure of my psychotherapy records be requested unless otherwise agreed upon. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Representative agrees to reimburse me for the entire time spent away from my office, including travel as well as any time spent on preparation at Therapist's usual and customary hourly rate. In addition, it is agreed upon I will not make any recommendation as to custody or visitation regarding Patient.

I give permission to allow referring person or agency to be thanked for referring me to Crossroads Counseling, I further give permission to Crossroads Counseling to place my name on their mailing list/emailing list that I may be informed of upcoming events, services or resources. Crossroads Counseling's mailing list will not be given or sold to any other individual or agency.

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Adult Consent for Treatment

I _____ authorize and request Darcy Greene to carry out psychological examinations, diagnostic procedures, and/or treatments that are advisable now or during the course of my care as a patient.

I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I have read, fully understand and agree to the policies and procedures stated in the Informed Consent Agreement and consent to being treated.

Date _____ Client's Signature _____

Date _____ Therapist's Signature _____

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Consent for Couples or Family Therapy

As a couple/family we agree to engage in therapy which will include both joint and individual sessions. I understand my right to confidentiality in individual sessions, but am willing to waive that right so that information shared in individual sessions can be shared in joint session at the discretion of the therapist.

I also understand that my therapist believes that couple/family therapy is most successful when a family is willing to be completely honest with the therapist and with each other. For this reason, my therapist has explained that he is unwilling to collude with secrets. Where a family member shares information with the therapist it will be discussed in joint sessions to maintain an atmosphere of openness and honesty.

I authorize and request Darcy Greene to carry out psychological examinations, diagnostic procedures, and/or treatments that are advisable now or during the course of my care as a patient.

I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I have read, fully understand and agree to the policies and procedures stated in the Informed Consent Agreement and consent to being treated.

Date _____ Family Member Signature_____

Date _____ Family Member Signature_____

Date _____ Family Member Signature_____

Date _____ Family Member Signature_____

Date _____ Family Member Signature_____

Date _____ Family Member Signature_____

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Consent to Treat Minor

1. 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 a parent or caregiver to give consent for psychotherapy, I will require copies of supporting legal documentation, such as a custody order, prior to the commencement of services.
2. When working with an individual child, I respect his/her right to confidentiality. I will consult with you about your child's progress. Both parents are entitled to know the nature and progress of the child's therapeutic services. If I am treating your child in individual sessions, I appreciate you telling me at the beginning of the session whether there have been any unusual happenings since our last session or issues of concern you wish to discuss prior to the child's session. This interchange must be brief so as not to interfere with the child's therapy session. If a more extended time is needed, please call for a separate appointment or request a telephone session. (See section concerning phone calls.)
3. Some children need to know their parent is present for them in the waiting room and sometimes we involve the parent in a special session. Please inform me if you plan to leave the office while your child is in session. If you do leave, please make sure you get back on time to pick up your child. Children should not be left unsupervised in the office at any time. Food is also discouraged in the office.
4. Since we may use art and play materials in therapy with children, please dress your child in clothing appropriate for messy play.

I _____ as parent/guardian of minor child named

_____ authorize and request Darcy Greene to carry out psychological examinations, diagnostic procedures, and/or treatments that are advisable now or during the course of his/her care as a patient. I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I have read, fully understand and agree to the policies and procedures stated in the Informed Consent Agreement and consent to being treated.

Date _____ Minor's Signature _____

Date _____ Parent/Guardian Signature _____

Date _____ Parent/Guardian Signature _____