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TREATMENT AGREEMENT 10/21

This document contains information about my professional services and business policies. Please read it carefully and jot down any questions so we can discuss them. When you sign this document, it will represent an agreement between us.

BENEFITS & RISKS: While most people benefit from therapy, it never guarantees success. The success of therapy depends on the complexity and severity of the problems addressed, the effort of the client, and the competence of the therapist. Some risks exist: You may experience uncomfortable emotions, and others may not approve of your new decisions or behaviors. We will begin by evaluating whether we each believe I can be of help to you. Please consider our first few sessions an exploration of whether we are a good match. Feel free to ask me questions about how I work and let me know if you have concerns about whether I am the right therapist for you.

AVAILABILITY: Office hours are on Tuesdays, Wednesdays, and Thursdays. Sessions last 45 minutes and begin on the hour. I schedule regular appointments weekly or every other week. If you are unable to meet that frequently I can scheduled you when a cancellation provides an opening.

CANCELLATIONS: If you are not able to make a scheduled appointment please contact me via email or phone as soon as possible. **The full fee will be charged for missed appointments without a 24 hour notice**. This advance notice enables someone else to fill that appointment time. Exceptions to this policy include a serious emergency or illness of the client or an immediate family member. There will also be no charge if you cancel **within the 24hours** for a communicable disease such as a cold or flu virus.

EMERGENCIES: You may telephone me at any time in an emergency. The voice mail will take your message and I will call back as soon as possible.

PAYMENT: The fee for the 45 minute session is payable by **check, cash or credit card.** The fee also covers an additional 10 minutes before the session to review your information or my notes from previous sessions as well as approximately 10 minutes after each session to record those notes.

INSURANCE REIMBURSEMENT: I can provide a monthly statement of services upon request. Be aware that an insurance company may require me to provide them with your clinical diagnosis, treatment plan, or even copies of my notes. I have no control over what the insurance company

does with your records. Please understand that, by using your insurance, you authorize me to release such information to them.

CONFIDENTIALITY: In general, the privacy of our communication is protected by law, and I will only release information about our work to others with your written permission. In most legal proceedings, you have the right to prevent me from providing any information about your treatement. There are, however, some exceptions:

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal information about your treatment. For example, if I believe that a child, elderly person, or disabled person is being or has been abused, I may be required to make a report to a state agency. If I believe a client is threatening serious bodily harm to another, I may be required to take protective action. If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members. If such situations arise in our work, I will attempt to discuss it with you before taking action.

In the event of a legal proceeding, you agree that neither you, your attorney, nor anyone else acting on your behalf will call on me to testify in court. In some legal proceedings, if a judge orders my testimony I must comply.

HOW TO CONTACT ME: I do not text message or use any social media platforms due to their unsecure nature regarding confidentiality. I use email with your permission but only for administrtive purposes such as setting, confirming, or changing appointments as well as for billing matters. Feel free to contact me via email for these matters. Please do not email me regarding your therapeutic issues as it is not secure regarding confidentiality. If you need to discuss a clinical matter, please feel free to call me so we can discuss it on the phone or wait to discuss it during our next session.

EXPERIMENTAL TECHNIQUES: I may ask you to use a technique called “muscle response testing”, which requires touching your wrist or fingers. I may also ask to test various substances suspected to be out of harmony with your body or to identify nutritional deficiencies. I will ask permission before using these optional techniques.

RELEASE OF LIABILITY: I understand that Tony Roffers, PhD is a licensed psychologist (PSY 3704) and not a medical doctor, and that I am not consulting him for the purpose of medical diagnosis or treatment but to obtain information and guidance on matters related to my psychological, emotional, and physical welfare, and that these cannot be separated. This guidance may include suggestions and recommendations about foods, nutritional supplements, exercise, detoxification, herbs, lifestyle modifications, energy balancing and other holistic health methods that may help my psychological as well as overall health. I understand that Tony Roffers is not advising me to forego the use of prescribed medications or other medical procedures. I acknowledge that nothing in the recommendations made or methods used by Tony Roffers is for the purpose of diagnosing, treating, alleviating, or curing diseases. I understand that I have the

right under the Constitution of the United States of America to exercise my freedom of choice in matters concerning my personal health and mode of health care. I therefore reserve my right to make such choices and do not hold Tony Roffers responsible for my decisions or the future outcome of my decisions. In consulting with Tony Roffers, I declare that I am not serving as an officer of the government, nor am I acting as an agent on behalf of government or private interests for the purpose of entrapment or investigation.

ACKNOWLEDGMENT: Your signature below indicates that you have read the information in this document and agree to abide by its terms. If you have any questions or concerns please bring them up with me before signing this.

_____	_____	_____
PRINT NAME	SIGNATURE	DATE

_____	_____	_____
THERAPIST'S NAME	THERAPIST'S SIGNATURE	DATE