



Heather Fabbre LMFT
Licensed Marriage Family Therapist
Registered Art Therapist

Informed Consent for Psychotherapy

Fees/Payments

Each 45-50 minute session is \$125.00. Patients with insurance are responsible for filling a claim and reimbursement. I will provide a super bill that will provide the necessary information for most PPO insurance plans. For private pay clients I reserve the right to periodically adjust fees and you will be notified of any changes 30 days in advance. **Initials** _____

Cancellations and Missed Appointments

Continuity is important in the therapeutic process, but if you need to cancel an appointment, please contact me at least 24 hours prior to the session or you will be responsible for paying for the missed session. (I understand if your child is sick and you are not able to give a 24 hour notice.) You will be billed \$125.00. I will only wait 15 minutes past our start time if you are late.

Please write down your credit card information and initial permission to use it for missed sessions.

Type of card _____ Name on card _____

Card number _____ Expiration Date _____

Signature _____

CHILD AND FAMILY THERAPY

A minor client will benefit most from psychotherapy when his/her parents, guardians, or other caretakers are supportive of the therapeutic process. If your child is the client, you are an important part of the therapeutic process and your ongoing involvement is essential for the best outcome. You may be asked to be involved in each session for all or part of the session. Family sessions also work best if parents are regularly involved. It is our policy that children are never left unattended in the waiting area. I may need to meet with parents separately to discuss your child's progress or frustrations. It is my policy to not discuss this in front of the child.

TREATMENT OF A MINOR

I generally require the consent of both parents prior to providing any services to minor children. If any questions exist I may ask you to provide supporting legal documentation, such as custody order, prior to commencement of services.

PROFESSIONAL CONSULTATION

Professional consultation is an important component of a healthy psychotherapy practice. 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.



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Appointments

Appointments are usually scheduled for 45-50 minutes. The practice's hours are by appointment only. Clients are generally seen weekly or more/less frequently as acuity dictates and you and I agree. In the event of an emergency, I may be reached by voicemail 24 hours – 916-622-0901. If you are unable to reach your psychiatrist or therapist, you may call your primary care physician, the local emergency room, the suicide crisis hotline at 916-368-3111, or Sacramento County Mental Health Crisis Staff at 916-732-3637.

Confidentiality

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include:

1. Suspected abuse or neglect of a child, elderly person or a disabled person.
2. When I believe you are in danger of harming yourself or another person or you are unable to care for yourself.
3. If you report that you intend to physically injure someone, the law requires me to inform that person as well as the legal authorities.
4. If I am ordered by a court to release information as part of a legal involvement.
5. When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc.
6. In natural disasters whereby protected records may become exposed.
7. As required by the Patriot Act.
8. When otherwise required by law.

You may be asked to sign a Release of Information so that I may speak with other healthcare professionals or to family members.

Record Keeping

A clinical chart is maintained describing your counseling goals and progress, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above.

Complaints

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, please inform me immediately and discuss the situation. If you do not feel the complaint has been resolved, you may also inform your insurance carrier and the Board of Behavioral Sciences to file a complaint if you so choose.



TERMINATION OF THERAPY

I have the right to terminate therapy at my discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, client needs which are outside my scope of competency or practice, or therapy does not seem to be benefiting the client. You or your representative has the right to terminate therapy at your discretion. Upon either party's decision to terminate therapy, I will generally recommend that the client participate in at least one terminating session, which is intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. I will also attempt to ensure a smooth transition to another therapist by offering referrals to other therapists.

RISKS AND BENEFITS OF THERAPY

Psychotherapy involves change, which may feel threatening not only to you but also to those people close to you. At times you may feel more vulnerable as you face destructive or painful information and behaviors. At the same time, psychotherapy can aid you in discovering tools and techniques that you can use to improve the quality of your life and your relationships.

As the client you have the right to ask questions of your therapist about professional qualifications, treatment objectives, and the plan of your therapy at any time in the therapeutic process.

Consent for Counseling

By signing below, you are stating that you have read and understood this policy statement and you have had your questions answered to your satisfaction.

*I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or counseling. I understand that I may withdraw from counseling at any time. I have also received a copy of the **Office Notice of Privacy Practices** which describes how medical information about me may be used and disclosed and how I can get access to this information.*

Name (please print) _____

Client Signature: _____ Date: _____

Guardians Signature: _____ Date: _____

Guardians Signature: _____ Date: _____

Therapist Signature: _____ Date: _____



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