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OFFICE POLICIES & GENERAL INFORMATION AGREEMENT FOR PSYCHOTHERAPY SERVICES

A clear framework for doing therapy can avoid misunderstandings and facilitate our working relationship. The following are policies under which I operate my practice. After you have read this material I will answer any questions you might have.

Client's Rights: You have the right to decide to end our psychotherapy work at any time without prejudice. If you wish, I will provide you with names of other qualified psychotherapists. You have the right to ask any questions about the psychotherapeutic process.

Confidentiality: All information disclosed within sessions and the written records pertaining to those sessions <u>are confidential</u> and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure are described to you in the Notice of Privacy Practices that you received with this form.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder, abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled (for more details see also Notice of Privacy Practices form).

Privileged Communication: The above refers to a client's right not to have confidential information revealed in court or other legal proceedings. Privilege is waived when 1) A client has consented specifically and in writing to disclose information; 2) When the client has disclosed a significant part of the information to a third party; 3) Or any of the following (Sections 910 through 1027 of the California Evidence Code) A) When the client is a minor under 18 years of age, the parent or guardian is holder of the privilege. B) When the client is in a criminal proceeding based on an insanity plea, or when a client introduces own mental health as issue in legal proceedings. C) When client alleges a breach of duty against the therapist. D) When client seeks help from the therapist to commit or plan a crime. E) When the client is dangerous to self or others. F) When client is under 18 years of age, is the victim of a crime and disclosing the information is in the best interest of the client.

I may occasionally find it helpful to consult other professionals about a case. During the consultation I will not give any identifying information about you to keep your identity anonymous. In addition, the consultant is legally bound to keep the information confidential.

Emergencies: If there is an emergency during our work together, or in the future after termination, where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the biographical sheet.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct me, only the minimum necessary information will be communicated to the carrier. I have no control or knowledge over what insurance companies do with the information I submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies' computers and soon will also be reported to the, congress-approved, National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access.

Both California Law and the standards of my profession require that I keep appropriate records of services provided. These records are kept confidential and are closely safeguarded.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on me, Dr. Locker, to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Telephone & Emergency Procedures: You may leave a message for me at (310) 850-3933. I check my messages during the hours of 11:00am- 7:00pm. In case of a true emergency, particularly one that is life threatening, you should go to your local emergency room or dial 911. When I am out of town and can not be reached by that number you will be informed in advance and I will make arrangements for another qualified therapist to cover any crisis that may arise.

E-mails, Cell Phones, Computers, and Faxes: It is very important to be aware that computers and email and cell phone communication can be relatively easy to access by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Additionally, my emails are not encrypted, and faxes can be sent erroneously to the wrong address. My computer is equipped with a password and I back up all confidential information from my computer to a hard drive on a regular basis. Please notify me if you decide to avoid or limit, in any way, the use of any or all communication devices, such as email, cell phone or faxes. If you communicate confidential or highly private information via email, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and I will honor your desire to communicate on such matters via email. Please, be aware that emails are part of the medical records, and do not use email for emergencies. Due to computer or network problems emails may not be deliverable. While I check my phone messages frequently during the day when I am in town, I do not always check my emails daily.

Fees, Cancellations, Insurance Reimbursement: The charge for your initial and subsequent sessions is $__________ . Payment is expected to be paid in full at the beginning of each 45-minute session. You may pay by cash or check. Fees are subject to change every six months. You will be charged $40.00 per 15-minute increments for any additional professional services rendered by me at your request, such as phone contacts over 5 minutes, preparation of special forms, insurance reports, consults with other professionals, etc.

Cancellations must be received at least 24 hours before your scheduled appointment; otherwise you will be expected to pay the fee for that missed appointment. You are responsible for calling to cancel or reschedule your appointment. Most insurance companies do not reimburse for missed sessions. Should your account become delinquent by a three month period, and you do not comply with a mutually agreed upon schedule of payment, your account may be turned over to a collections agency. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorneys' fees.

If you would like to submit a bill to your insurance company for reimbursement, please let me know and I will provide you with an invoice at the end of each month. As was indicated in the section, *Health Insurance & Confidentiality of Records,* you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are the focus of psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.

Therapist's Incapacity or Death: You acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, you give consent to allow another licensed mental health professional selected by the undersigned therapist to take possession of your file and records and provide you with copies upon request, or to deliver them to a therapist of your choice.

Termination: As set forth above, after the first couple of meetings, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals that you can contact. If at any point during psychotherapy, I assess that I am not effective in helping you reach the therapeutic goals, I am obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, I would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition.

About Psychotherapy: Helping you reach your goals in therapy is the purpose of our work together. You can do your part by openly and honestly communicating your thoughts and feelings, even though this may be difficult at times. You may feel worse before you feel better. There is a risk of discussing unpleasant events, and you may feel anxious, depressed, frustrated, or hopeless at times. These feelings are a normal part of the therapy process, and are usually temporary.

We will work together to get through the difficult times. If you are ever concerned that our work together is not helping, please give me feedback so we can discuss it. In addition, I welcome referrals, which signify your satisfaction and trust in my services.

Consent To Treatment: By signing below, you, the undersigned client, acknowledge that you have read and understood these policies and that ample opportunity has been offered to ask questions and to seek clarification of anything unclear to you.

Client: ____ Date: ____________

Guardian (if a minor): ____________________________________ Date: ____________

As witnessed by: Therapist: _______________________________ Date: ____________