Courtney Breed, LCSW

659 Cherry Street, Suite 202

Santa Rosa, CA 95404

LCS#75886

707-634-4632

**Office Policies and Consent for Treatment**

*This document provides you with information about my psychotherapy practice, my policies regarding scheduling and payment, and important legal and ethical information. Please read carefully and ask me any questions you have before signing.*

**Confidentiality**: The information discussed in therapy is strictly confidential and will only be released with your written permission UNLESS: (1) I am ordered by the court to release or disclose information regarding your mental status. (2) There is reasonable cause to believe you are a danger to yourself or others or you are gravely disabled. (3) Where there is reasonable cause to believe physical, sexual, emotional abuse of a minor, an older adult (65 y/o+), or a dependent adult exists. In the latter two cases the law mandates disclosure of information to potential victims and/or legal authorities so that protective measures can be taken.

In addition, to best meet your needs and to continue to grow as a therapist, I may consult/train with colleagues who are bound by the same confidentiality rules, and in such consultation/training, I will remove or change identifying details to the greatest extent possible.

**Fees:** My full fee is $115 per 50-53 minute session. The fee for your sessions is $\_\_\_\_\_\_\_\_ per 50-53 minute session. You are responsible to pay for services at the beginning of each session. Please have your check, cash, or credit card prepared at that time. You will be charged your full fee for any late cancellations or no shows. Each January I may raise my rates by a slight amount ($5 or so) in order to respond to inflation and cost of living increases. I occasionally have a few slots available for clients that need a lower fee, please ask if this is something you may need.

**Insurance:** If you have coverage with Medi-Cal/Partnership/Beacon, once you have received preauthorization, I can bill them for our sessions. I do not bill private insurance carriers directly. If you wish to be reimbursed by an insurer, I will provide a statement for you to submit so that all reimbursement is paid directly to you. I cannot and do not guarantee reimbursement as this matter is entirely in the hands of the insurer.

**Communications**: If you need to contact me between sessions, please call 707-634-4632. If you leave a message M-F and would like me to return your call I will make all efforts to do so within 24 hours. If you leave a message on a weekend your call most likely will be returned the following Monday. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away, you can call the 24-hour crisis line at **(800) 746-8181** or call 911.

**Cancellations / Vacations**: I appreciate as much advance notice as possible if you are going to miss a session, ideally at least 24 hours in advance. Because I have set aside the time for you, all appointments cancelled less than 24 hours in advance will be billed at the usual rate, unless it is an emergency. If you are more than 20 minutes late and have not called to let me know, I will assume that you are not coming to that session and you will be charged for the session. Medi-cal/Beacon will not reimburse me for your missed sessions. I take a total of 4-5 weeks off during the year. I will endeavor to give you as much advance notice as possible. A qualified mental health professional will cover my practice while I am away.

**Emergencies**: If you are having a psychiatric emergency you can call the **24-hour Emergency Mental Health Hotline: (800) 746-8181 or take yourself to the** Sonoma County Crisis Stabilization Unit located at 2225 Challenger Way, Santa Rosa, CA 95407, (707) 576-8181, or call 911. If there is an emergency during our work together and I become concerned about your personal safety I will do whatever I can within the limits of the law to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided as your emergency contact on the Personal Data Form.

**Treatment Planning and the Therapy Process:** Psychotherapy can be a fascinating and stimulating process. Although there can be no assurance of positive results, participation in therapy *can* result in a number of benefits, including regulation of anxiety and emotion, improvement in mood, enhanced self-esteem, as well as improvements in relationships and in job/academic performance. I may ask for your feedback about the therapy so that I can best tailor my approach to meet your needs. You will gain the most benefit from psychotherapy if you are actively involved, honest, open, and willing to collaborate in the process. Please be aware that remembering or talking about unpleasant events, feelings, or thoughts can be uncomfortable, disorienting and may cause strong feelings of anger, sadness, and/or anxiety. Change will sometimes be easy and swift, and at other times, slow and challenging. Sometimes more than one approach is helpful in dealing with a certain situation and during the course of therapy, I may utilize various psychological approaches.

**Termination**: We may both feel after a time of working together that you have completed an important piece of work and are ready to stop therapy, and/or you may need to stop for other reasons. The therapy completion/closure process can be very empowering and healing for clients, thus I recommend at least 1-3 sessions specifically dedicated to processing the end of therapy, if appropriate given the circumstances.

**Required message from the BBS:** “The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of Licensed Clinical Social Workers. You may contact the board online at [www.bbs.ca.gov](http://www.bbs.ca.gov), or by calling (916) 574-7830.”

**Consent for Treatment**:

I have read this Office Policies and Consent for Treatment carefully and have received a copy. I understand this agreement and agree to comply with it:

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Client name (print) Signature Date

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Street Address City State Zip Code

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Mailing Address City State Zip Code

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