Amy Collins, M.S. MFT
Marriage and Family Therapist, #MFC 43835
1528 Eureka Rd. Ste 101
Roseville, CA 95661
(916) 759-1133

Informed Consent for Psychotherapy

FEES:

- Fees are payable at the time of service, unless otherwise agreed upon. Cash and checks are accepted. Checks may be made to Amy Collins. Returned checks will be assessed at $25 service charge.
- Fees are $125 per session. Unless otherwise agreed, sessions are 45 minutes in length. Fees should be paid at the beginning of session. Payments received more than 7 days after the date of service will be billed and assessed a $10 charge.
- The hourly fee for written reports is $150 per hour.
- Telephone therapy is available on a limited basis and will be charged at the hourly rate in increments of 15 minutes rounded to $25. These fees will be communicated and agreed upon at the time of service by Therapist and Client and either billed or payable at the next appointment. These fees do not include brief phone calls of less than 5 minutes or calls related to scheduling of appointments.
- Missed or cancelled appointments will incur the full charge of $125 per session, unless a 24 hour notice is given. This is payable at the next visit, or within 7 days. You may leave a message at any time on my voicemail that will be time stamped in order to cancel or reschedule an appointment.

INSURANCE:

- The insurance contract is between you and your insurance company and, therefore, the responsibility for fees is yours, even if you have a policy that contributes toward the cost of psychotherapy services. You are hereby agreeing to pay the full amount of the fee that is not covered by the insurance reimbursement. Since it may not be clear what the reimbursement will actually be until the first insurance billing is paid (usually 4-6 weeks), you will need to pay the full fee at the time of your visits, and seek reimbursement from your insurance company. I will be happy to assist you in filing your claim, by providing a monthly HCFA 1500 form with all of the necessary information.
- In order for your claim to be processed, you must sign a release that allows disclosure of confidential information, including a diagnosis, to the insurance company.
- Insurance companies do not pay for missed appointments; you will be responsible for the full fee if you miss a scheduled visit with less than 24 hours notice.

CONTACTING ME:

- This business is a sole proprietorship and is not an entity of Hope Counseling Center.
- A private, confidential message can be left on my voicemail at (916) 759-1133. I check my messages throughout the day, Monday through Thursday, from approximately 9am to 6PM. I will return your call as soon as possible. I do not check messages on the weekend, evenings, or on holidays, unless otherwise arranged. Please leave a call-back number and times that are best to call you, as it can be difficult to reach me between appointments. In order to protect your confidentiality, please also include in your message if it is ok for me to leave back a message for you and /or state who is calling for you. If your call is not returned within 2 days, please call again, as technical problems can occur.
- If your situation is of an urgent nature, please make this clear in your message, and I will make every effort to call you immediately. If your situation is an emergency and it is after hours or on a weekend or holiday, you may utilize the following 24-hour referrals, contact your local hospital or call 911.

Roseville Mental Health Services	916-787-8800
Roseville After Hrs. Emergency Services	530-886-5401
Sutter Roseville Emergency Services	916-781-1533

CONFIDENTIALITY:

- One of the most important rights as a client involves confidentiality. With certain exceptions, information revealed by you during therapy will be kept confidential (including the fact that you are even a client here). This information will not be revealed to others outside this office without your written permission
- There are certain situations where I am required or permitted by law to reveal information obtained during therapy to another person or agency without your authorization. This includes (but its not limited to)"
    - Reporting suspected child abuse, adult elder or adult dependent abuse
    - Serious threats of harm to yourself or others
    - Judicial Subpoenas

  Your rights to privacy and how your private information is released are detailed in the attached NOTICE OF PRIVACY PRACTICES. Please read and keep a copy of this form for your reference.

I have received a copy of the NOTICE OF PRIVACY PRACTICES:_____
(initials)

As a 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.

About the Therapy Process

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

I have read, understand, and agree to the information provided to me in this consent form and I have received a copy of this form and the Notice of Privacy Practices.

_____ _____
Client Date

_____ _____
Client Date

_____ _____
Therapist Date

____My therapist may call me at my home. My home phone number is: ( ) _____

____My therapist may call me on my cell phone. My cell phone number is: ( ) _____

____My therapist may call me at work. My work phone number is: ( ) _____

____My therapist may send mail to me at my home address. _____

____My therapist may send mail to me at my work address. _____

____My therapist may communicate with me by email. My email address is: _____

____My therapist may send a fax to me. My fax number is: ( ) _____