Eveline Smilack, MFA, LMFT
Licensed Marriage & Family Therapist #91090
Practice of Psychotherapy

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(310) 869-1533

INFORMED CONSENT: PRACTICE POLICIES

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

FEES: The fee for a 50-minute session (therapy hour) is $200.00 payable at the beginning of each session unless we make other arrangements. Conjoint sessions are often longer. You will be charged on a pro-rata basis for that time. For example, a session that is 1.5 hours (50 minutes plus 25 minutes) equals a fee of $300.00. We will reevaluate your fee, should your circumstances warrant a fee adjustment, or when I initiate my annual increase, usually in the autumn of the year.

Payments are accepted by CHECK, CASH, or CREDIT CARD at the beginning of each session, unless we make another arrangement. For example, you may wish to pay monthly. For each returned check, you will be charged an additional $25.00.

Your fee will be: ________ Paid by the: wk. ___ mo. ___ (initial_____)

If we schedule a telephone session, you will be billed for that session at the usual fee and cancellation policies apply. I do not charge for brief, less than 10-minute, phone calls between sessions, unless they become numerous, which might indicate a need for more frequent weekly sessions.

You will be charged $50.00 per 15-minute increments for any additional professional services rendered by me at your request, such as phone contacts over 10 minutes, preparation of special forms, insurance reports, consults with other professionals, etc.

SCHEDULING: I recommend attending TWO or more sessions per week to get the best therapeutic results. However, many clients come once a week with good results. We will decide upon a specific day and time for your session(s). I will set the time(s) aside for you. If you cannot attend the regularly scheduled time(s), please contact me to cancel the session.

CALLS AND MESSAGES: You may leave a message for me on my confidential voicemail: (310) 869-1533. Non-urgent phone calls are returned during normal workdays (Sunday through Friday) within 24 hours. If you have an urgent need to speak with me or want a return call, please indicate that in your message.

EMERGENCIES: 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 cannot 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.

CANCELLATION POLICY: You are responsible for calling to cancel or reschedule your appointment. If you cancel or reschedule, for any reason, you must do so with 24 hours advance notice. If you do not call 24 hours in advance, you will be charged the full fee for the scheduled session. (This means a FULL 24 Hours—not, for example, 23 Hours and 55 minutes.) Please CALL to cancel a session DO NOT email or text to cancel.

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.

Should I miss a scheduled session with you or double-booked your session, or if you have arrived at my office and I am not able to see you at that time, I will provide you a session at no charge. Obviously, these would be unconscious oversights. Most frequently, I am able to contact you should an emergency occur and I cannot be there for our appointment.

***CONTAGIOUS ILLNESS**: If you are feeling really bad, and contagious, I may not want to see you in that condition. If you are in doubt, call and ask me.

INSURANCE: If you wish to bill your insurance company for your sessions, I will provide a monthly invoice for you to send to your insurance company. You must pay me in full as per our agreement. I bear no responsibility for ensuring you receive insurance reimbursement.

Be sure to check your benefits before you start treatment. 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.

CLIENT RIGHTS: You have the right to question any aspect of your treatment. You may expect, as well, that I will maintain professional and ethical boundaries with you, not entering into any personal, financial, or professional relationship which could compromise our therapeutic relationship.

Should I not meet your needs, you have the right to end your therapy, at any time, for any reason you may deem appropriate, without any obligation except for the fees already incurred.

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.

Our first sessions will involve a history taking and evaluation. During that time, we can determine if I am the best professional to meet your treatment goals. Through the course of therapy, I will draw upon a variety of approaches according, in part, to the issues being treated and my assessment of what will benefit you including cognitive behavioral therapy, dialectical behavior therapy, psychodynamic psychotherapy, and EMDR.

INFORMED CONSENT: LIMITS OF CONFIDENTIALITY

Communication between therapist and patient, disclosed within session and in written communication pertaining to those sessions, is both privileged and confidential. This means I cannot discuss your case orally, or in writing, with anyone without your (client's) written permission, except where disclosure is required by law. All of our communication will remain confidential unless you request otherwise by signing a RELEASE OF INFORMATION.

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.

There are exceptions to the above. *A therapist has an ethical and/or legal obligation to break confidentially under the following circumstance*s:

1. If you intend to harm another person, I am legally bound to warn the authorities and/or the person or the family of the person, to whom you report intent to harm.
2. If you disclose that you, or someone you know, were in the past, or are currently involved in abuse or neglect of a child, elder, or disabled or dependent person, then I am legally required to make a report to the appropriate authorities.
3. If you disclose downloading, streaming, or accessing images of a minor engaged in an act of obscene sexual conduct, including child pornography, then I am legally mandated to make a report to the appropriate state agencies.

4. If you pose a life-threatening danger to yourself, it is my duty to warn the authorities and/or your family members.
5. If you become involved in legal proceedings that involve your medical or mental health, you may be waiving some of your rights to confidentiality. In such case, your medical records (which include my records) may be subpoenaed. Questions regarding the limits of confidentiality under those circumstances should be discussed with your attorney.
6. When you sign an insurance claim form, you are waiving your right to confidentiality and granting them access to your records, should they desire to obtain them. If your therapy sessions are covered by insurance, the insurance company will require, at minimum, a diagnosis and dates of service.

HEALTH INSURANCE EXCEPTION TO CONFIDENTIALITY: Although I am not on any insurance panels, if you choose to bill your own insurance company, disclosure of confidential information will be required by your health insurance carrier in order to process the claims. If you instruct me to provide you with a statement to bill your insurance, only the minimum necessary information will be communicated to the carrier. I have no control over, or knowledge of, what insurance companies do with the information I submit or who has access to this information once I release it**.**

RECORDS AND REVIEW: By law and profession standard requirements, I keep treatment records for at least 7-years. Unless otherwise agreed to be necessary, I retain clinical records only as long as is mandated by California State law. If you have concerns regarding the treatment records, please discuss them with me. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal, emergency circumstances, or when I assess that releasing such information might be harmful in any way. In such a case, I will provide records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, I will release information to any agency/person you specify unless I assess that releasing such information might be harmful in any way.

LITIGATION LIMITATIONS: 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, Eveline Smilack, to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

E-MAILS, CELL PHONES, COMPUTERS, AND FAXES: It is important to be aware that email and cell phone communications can be relatively easy to access by unauthorized people, and can compromise the privacy and confidentiality of these types of communication. I use HIPAA compliant email services; however, your Emails servers are vulnerable to unauthorized access to all that pass through them or are stored online. To protect your confidentiality, my computer is equipped with a firewall, virus protection, and password authentication. I back up all confidential information from my computer on a regular basis onto an encrypted hard-drive. My cell phone is password protected.

Please notify me if you decide to avoid or limit, in any way, the use of any or all communication devices, such as email or cell phones. If you communicate confidential or private information by email or text, 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 and texts are part of the medical records.

Do not use email for emergencies or appointment cancellations. 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.

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.

I have read and understand the Practice Policies, including Cancellation Policy, and Limits of Confidentiality described above. I consent to treatment with Eveline Smilack, MFA, LMFT.

Name (Print): ____ **Date:** _________________

Signature: ____

Guardian Name (Print): ____ **Date:** _________________

Signature: ____

As Witnessed By Therapist:
Name (Print): ____ **Date:** _________________

Signature: ____