

Bay Area Marriage, Family & Child Counseling
Shalini Dayal, MFT 43574
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Disclosure Statement & Agreement for Services

Introduction

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

Information about Your Therapist

At an appropriate time, your therapist will discuss his/her professional background with you and provide you with information regarding his/her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience and professional orientation.

Your therapist is a: **Licensed Marriage and Family Therapist**

Information About This Practice

<u>Shalini Dayal</u>	<u>MFT 43574</u>
Name	License Type & License Number

Fees and Payment Policy

The full fee for service is **\$200.00** per individual and **\$200** for conjoint (marital /family) for all initial and ongoing therapy sessions. Individual Sessions and conjoint (marital /family) sessions are approximately **45 minutes** in length. **There is also a charge for any written documents requested by you for personal and/or legal purposes such as, but not limited to, court and also for telephone consultations with any other providers and/or court at the rate of \$250 and onwards. These are billed at 10 minute increments. Please note services such as any court mandated or recommended individual or family therapy, reunification or supervised visitation therapy or recommendations and reports for courts and others are not covered by your insurance, hence will be billed to you directly.** Occasionally there will be fee increases. Fees are payable in full at the time that services are rendered. Your therapist accepts check or cash only.

Please inform your therapist about method of payment for services. **Your provider does not accept any insurances**. Please note your therapist provides you with a Super Bill for reimbursement with your insurance. If your therapist/provider is a contracted provider for your EAP company, your therapist/provider will discuss the procedures for billing your EAP. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. If you choose to not use your EAP, please indicate and initial. **Please circle & initial: EAP() Self Pay ()**

You should be aware that insurance/EAP plans generally limit coverage to certain diagnosable mental conditions only. You should also be aware that **you are responsible for verifying and understanding the limits of your EAP coverage**. Although your therapist/provider is happy to assist your efforts to seek insurance / EAP reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. Your therapist will file your EAP claims (for contracted clients), but you are responsible for deductibles, co-insurances and co-payments. It is your responsibility to familiarize yourself with your insurance benefits. Please discuss any questions or concerns that you may have about this with your therapist.

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If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time. Your therapist accepts cash or check only, NO credit cards. However, if the check is returned due to insufficient funds or incorrect account information, you are responsible for all charges incurred on your account as well as the therapist's. **There is a fee of \$35 for every returned check**

You are also responsible for any fees incurred by the therapist for time or expenses incurred filing any **legal or small claims courts claims** or using a **collections agency** for lack of payment of services rendered which includes **payment for No shows and late cancellation. Please note, when any collection agency or court is involved, your confidentiality is compromised. Unpaid debt is also reported to agencies including but not limited to, Credit Bureaus and Credit reporting agencies/businesses.**

Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission or it is court ordered, to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, your therapist will not disclose information communicated privately to him or her by one family member, to any other family member without written permission.)

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

There is **no confidentiality rule** applied when therapy is court ordered, for Therapeutic visitation and family Reunification or when ordered/mandated by one's manager/employer. Please note, in such cases, the process is **NOT** confidential and the therapist is obligated to report back to the one mandating the therapy.

If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with her, when working with other members of your family. Please feel free to ask your therapist about his or her "no secrets policy and how it may apply to you.

Your confidentiality is also compromised in case of unpaid debts owed to your therapist. Please see above mentioned Section for payment policy.

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Therapist Communications

I do not communicate with clients via email, only via a phone number, including sending out text reminders only for appointments, so please indicate the number you prefer me to call and send text reminders. Also, by agreeing to giving your number, you are allowing me to text you appointment reminders

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least **48 business/weekday hours** in advance of your appointment. If you do not provide your therapist with at least 48 business hour notice in advance, you are responsible for the full payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions. You will be billed at the full fee rate of **\$180 and \$200** for No Show and cancellation less than **48 (weekday/ business hours)** hours notice. Holidays and weekends are not included as weekdays.

Therapist Availability/Emergencies

Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions. **The charge for phone consultations and voicemails, is in increments of 10 minutes, based on hourly rate of \$180 per hour.** This is not covered by your insurance, and will be billed directly to you. ___(Client Initials)

You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail.

You should be aware that your therapist is generally available to return phone calls within approximately 48 hours. Your therapist is not able to return phone calls after 7 P.M. on weekdays. Your therapist is also not available to return phone calls on vacations, holidays, Saturdays and Sundays.

Please write the **name and number of an Emergency Contact person** you give your therapist permission to contact in case of an emergency: Name & Phone Number: _____

In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis: **Crisis Hotline: (800) 309-2131** **Youth Crisis: (800) 448-4663**
Domestic Violence Help: (510) 794-6055 **Alameda County Child Protective Services: (510) 259-1800**

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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. Therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Please note, you are responsible for choices you make in your treatment and your therapist recommendations are not mandatory. Your therapist will also periodically provide feedback to you regarding your progress & 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. In court and employer mandated therapy, the therapeutic goals are pre-set by those requesting the therapy. Also, any discussion of alternate treatment modalities, including but not limited to any non-psychotherapeutic treatment, is intended for information only and not as a recommendation or advise.

Written Reports/Summary of Treatment/Court Appearances

Please be advised that your therapist does not write summaries for you for court or appear in court on your behalf. Your therapist charges an initial **\$5000 for showing up at court** for the following but not limited to, depositions or as an expert witness, an additional hourly rate of **\$500** per hour, billed in increments of 10 minutes, for any requests of written reports or summaries of treatment with me or if your therapist is deposed or subpoenaed to appear in court on your behalf, any depositions at any location, including time spent traveling to and from and waiting for above mentioned activities.

If you want a **written or verbal summary** of your treatment, for yourself or any other provider to further assist with your treatment, please be advised your therapist charges a flat rate of **\$250 per one page document**. Any additional time spent for the following, but not limited to, gathering information, calling other providers, etc., printing and mailing fees at **\$250 per hour, billed in 10 minutes increments**, are involved.

Please be advised, any court involvement will compromise your confidentiality and the therapist is no longer responsible for any liability that arises out of any court involvement.

Termination of Therapy

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.

Your signature indicates that you have read this agreement for services carefully and understand its contents. Please ask your therapist to address any questions or concerns that you have about this information before you sign.

Signature Relationship to Client Date: ___/___/___

Signature Relationship to Client Date: ___/___/___

Signature Relationship to Client Date: ___/___/___

Please download a copy of this form for your records