Feel Better Counseling
Kathleen Jeanne Troncao-Heath; Licensed Marriage & Family Therapist; LMFT#77993

AGREEMENT FOR SERVICE / INFORMED CONSENT

Fee and Fee Arrangements: I understand that I will be paying for my own psychotherapy and that the fees are as follows: Initial Evaluation (70-80 minutes) $140; $100 per 50 minute session; $115 per 53-60 minute session; $130 per 70 minute session; $60 per 30 minute session; phone calls 10 minutes or longer - $2/minute; $75 per late cancellation or no-show

- Fees are payable at time service is rendered.
- Fees may be periodically adjusted. I will be notified of any fee adjustment in advance.

From time-to-time, Therapist may engage in telephone contact with me or third parties at my request. I am responsible for payment for any telephone calls longer than ten minutes.

Insurance: I am aware that insurance plans generally limit coverage to certain diagnosable mental conditions. My therapist is unable to guarantee that my insurance will pay for or reimburse for the services provided. I am responsible for any and all fees including but not limited to deductible, co-insurance and charges not paid for by my insurance company. I am responsible for verifying and understanding the limits of coverage. If I choose use my insurance, I understand that my insurance company may require the release of certain treatment information including, but not limited to diagnosis, treatment plan, and treatment summary. Any information released to my insurance company becomes part of my permanent health record.

Risks and Benefits of Therapy Psychotherapy is a process in which I will discuss a number of issues, events, experiences and memories for the purpose of creating positive change so I can experience life more fully. Psychotherapy is a joint effort between me and my therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Participating in therapy may result in a number of benefits, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits require effort on my part, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which my therapist will challenge my perceptions and assumptions, and offer different perspectives. The issues presented may result in unintended outcomes, including changes in personal relationships. I am aware that any decision on the status of my personal relationships is my responsibility. During the therapeutic process, I may feel worse before I feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. I will address any concerns regarding my progress in therapy with my therapist.

Confidentiality All communications with my therapist is generally confidential. There are exceptions to confidentiality, including but not limited to:

1. I authorize release of information with my signature (or parent/guardian).
2. When release of information is mandated by a court of law.
3. I bring into issue my mental or emotional state in a legal proceeding.
4. I express threats of violence towards myself and/or an identifiable person or their property.
5. My therapist suspects child, elder or dependent neglect, endangerment or abuse.

Note: In instances 4 & 5, my therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken.

- If I participate in couple, family or group therapy, my therapist will not disclose confidential information about treatment unless all person(s) who participated in the treatment provide written authorization for release.
- My therapist utilizes a "no-secrets" policy when conducting family or marital/couples therapy. This means that if I participate in family, or couple therapy, my therapist is permitted to use information obtained during individual interactions when working with other members of my family. Please feel free to ask about the **"no secrets"** policy.
- If I am using my insurance, I understand that my insurance company will have access to information in my file.
- My therapist utilizes an electronic health record, billing service and office assistant these services require access to

information in my file for management and billing purposes and my file will be treated confidentially. If I choose to utilize text or email communications or receipts, I am aware that these formats may not confidential.

Minors and Confidentiality Communications between therapist and clients 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. I understand that my therapist may discuss the treatment progress of a minor client with the parent or caretaker. I will discuss any questions or concerns with my therapist.

Therapist Availability Therapist's office is equipped with a confidential voice mail system that allows messages to be left at any time. Therapist is generally available after hours for urgent calls. Therapist will make every effort to return non-urgent calls within 24 business hours.

Emergencies: My therapist does not provide emergency services. If there is an emergency involving a threat to my safety or the safety of others, of I require immediate medical or psychiatric, I will use the following resources:
Life threatening emergency: call **911**
Kern County Crisis Hotline*:* 1-800-991-5272 (available 24 hours a day, 7 days a week)
Suicide Prevention Hotline*: 1-800-273-8255;*

Peer Consultation: My therapist may seek issue focused, peer consultation and that my identity will by fully protected.

Litigation My therapist will not voluntarily participate in any litigation, or custody dispute. My therapist has a policy of not communicating with attorneys and will not write or sign letters, reports, declarations, or affidavits to be used in legal matters nor provide records or testimony. I will reimburse my therapist for any time spent for preparation, travel, or other time should my therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving me.

Cancellation Policy I am responsible for payment of the agreed upon fee for any missed session(s) and for payment of the agreed upon fee for any session(s) for which I failed to give at least 5 hour notice of cancellation. Cancellation notice should be left on therapist's voice mail or via text message at (661) 383-0378.

Termination of Therapy Therapy is generally concluded once therapy goals have been met. If no progress has been made towards meeting therapy goals or circumstances have arisen that make it unlikely therapy will be successful, my therapist will discuss the possible need for termination and/or referral. My therapist will maintain open discussions about concluding therapy.

Acknowledgement: ***By signing below, I acknowledge that I have reviewed, understand and agree to the Informed Consent. I have received a copy of my therapist's Privacy Practices.***

_____	_____	_____
Name (please print)	Signature	Date
_____	_____	_____
Name (please print)	Signature	Date
_____	_____	_____
Parent/Guardian (please print)	Signature	Date
_____	_____	_____
Parent/Gruardian (please print)	Signature	Date

SIGN IF using your INSURANCE: I authorize the release of any information necessary (including notes, treatment summaries and diagnosis) to my insurance plan to process my reimbursement, determine medical necessity.

_____	_____	_____
Signature	Signature	Date