Welcome to my office. The following guidelines are intended to clarify our working relationship and to enhance your therapeutic experience. Feel free to discuss with me any question you may have concerning this information.

**Patient’s Rights**: Our relationship is strictly voluntary and you may leave the psychotherapy relationship anytime you wish. It is customary and advisable to discuss the termination of therapy to ensure proper closure. Should inpatient care become necessary at any time, therapeutic responsibility will be transferred wholly to the attending staff of the facility.

**Fee for Service**: If you are covered by health insurance, please be aware that your policy is a contract between you and your insurance company. I will make every effort to verify your insurance, however I only accept limited insurance and some insurance companies do not reimburse for sessions held by a non-contracted provider. I will provide you with a statement to submit for reimbursement. Simply attach it to your claim form and send it to your insurance company. If your claim is rejected, for any reason, you are entitled to an explanation, but it does not relieve you of your financial obligation for services provided. You are expected to pay each visit. To allow for the maximum amount of time in each session, please have your check prepared in advance made payable to Melanie Masters, MA, LMFT. Applicable bank charges will be added for any returned checks. You may also pay by cash or credit card. If you do not pay at the end of the session, I will provide you with an envelope in which to mail your payment. The hourly consultation fee is $\_\_\_\_\_\_\_ per therapy session (45 – 50 minutes). Please feel free to discuss payment options with me.

With some insurance plans, it might be necessary for your personal doctor to write a prescription recommending therapy.

**Appointment Scheduling and Cancellation Policies:** Sessions are typically scheduled to occur once per week at the same time and day if possible. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify me at least 24 hours in advance of your appointment. **If you do not provide me with at least 24 hours notice in advance, you are responsible for payment for the missed session.** **Please note that cancellations must be made by phone and not by email.** Please understand that your insurance company will not pay for missed or cancelled sessions. Late arrivals to sessions will end at the regularly scheduled time and be charged the full fee.

**Therapist Availability by Phone/Emergencies:** Telephone calls are for setting appointments or short messages. I will make every effort to return calls as soon as possible should you need to speak with me. If more than a few minutes on the phone are required, I will ask you to schedule a session. In the event that lengthy telephone contact is required or requested, you will be charged at the regular session rate. If you wish a return phone call and you have a blocked-private number, please unblock it by dialing (\*82) prior to placing your call.

**About the Therapy Process:** It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that we are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I 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 client, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

**Termination:** This is an extremely important aspect of your work. It mirrors many of life’s situations. Therefore, I ask you to respect our process and work through any feelings you have at the time. Please be willing to spend a minimum of two sessions discussing the termination, even if you experience discomfort and anxiety. The knowledge and growth you gain through this process is what is most important. You may discontinue therapy at any time. If either of us determines that you are not benefiting from treatment, either of us 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.

**Confidentiality:** Information shared in my office is kept confidential, including that of minors. The EXCEPTIONS TO THAT ARE AS FOLLOWS:

1. When a client communicates threat of bodily harm to another, or themselves.
2. When there is reasonable suspicion that child abuse or elder abuse has occurred or will occur.
3. When information is required by law or ordered by the court.

If you participate in marital or family therapy, I 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 I utilize a “no-secrets” policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or marital/couples therapy, I am permitted to use information obtained in an individual session, when working with other members of your family. Please feel free to ask me about my “no secrets” policy and how it may apply to you.

Any outstanding debt may be placed in the hands of an agency or attorney for collection after a reasonable time. This will necessitate the release of pertinent demographic information as well as accounting information. No therapeutic information will be released.

I have read and fully understand the conditions and the responsibility of this agreement.

**Cell Phones:** Please make sure that you turn your cell phone off while in the office suite.

**Client Signature Date**

**Client Signature Date**

Parent Signature if client is a minor

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Client Information** (Please Print Clearly)

**Client Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_\_

* Minor Unmarried Married Separated Divorced Widowed Engaged

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number & Street City State Zip

Home Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Soc. Sec.# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver’s License # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*May I leave a message at the above phones/address/email?* \_\_\_yes \_\_no *If not, where may a message be left?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse or Parent Name** (If Applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number & Street City State Zip

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Closest Friend or Relative, Not Living At Your Home, To Contact In Event of Emergency**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name, First

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number & Street City State Zip

**Party to Take Financial Responsibility for Counseling (If same as ‘client’ indicate ‘self’)**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name, First

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number & Street City State Zip

**Referred By** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received counseling from other professionals in the past? \_\_\_\_\_\_\_\_

If yes, when and with whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Please list current prescription medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list current non-prescription medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List past surgeries or major illnesses and dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Agreement and Authorization for Treatment**—I authorize treatment of the person(s) named above and agree to pay all fees & charges for such treatment at the time of service unless other arrangements are agreed upon in writing.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand that all CANCELLATIONS MUST BE MADE 24 HOURS IN ADVANCE OTHERWISE A FULL CHARGE WILL BE MADE. (Insurance does not reimburse for late cancellations or for any cancelled sessions). I will be fully responsible for such charges.**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_