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Practice Policies & Informed Consent

Welcome! The following information provides an overview of my therapy practice policies. Please review each section carefully before signing on the last page. I encourage you to ask questions.

The initial assessment period will likely take 2-3 sessions. During this time, I will gather information from you to fully understand what brings you in for therapy and get to know more about your personal history. In these first sessions you are invited to learn more about my approach and to get a sense of whether developing a relationship with me will be helpful to you. At the end of this process, we will decide together how to proceed. If we agree that there is an appropriate “fit,” we can decide how to proceed with therapy. If not, I will provide you with referrals and help you develop a plan to find a therapist better suited for your needs.

I value your commitment in entering therapy and am aware of the time, energy, and money involved. If you have questions or concerns that arise during therapy, I hope you will bring them up. In the event that either you or I decide that I am not the best therapist to work with you, we can discuss this and decide how to proceed.

After the initial evaluation, you will be encouraged to discuss those issues of most concern to you. In contrast to the initial evaluation phase, where I will be directive and asking many questions to learn more about you and your concerns, at this point you will “take the lead” and your work with me will be much more collaborative.

The therapeutic hour is ___ minutes. Sessions are typically held on a weekly basis and, in some cases, more frequent visits may be arranged. After a period of weekly visits, less frequent visits may be appropriate and we can discuss this option.

Contact & Availability

I check phone messages frequently and am usually able to return calls within 24 hours, with the exception of weekends and holidays. There may be instances when I may take longer than 24 hours to get back to you. When you leave a message, please be sure to leave your phone number and good times to reach you.

In the event that we communicate via email, it will be regarding practical matters (e.g., making an appointment). Only in rare cases that are discussed in advance am I willing to communicate about clinical issues (e.g., something we have discussed in therapy) via email. This is because email is not completely confidential. All emails are retained in the logs of email service providers and can be read by the system administrator of the Internet service provider.

While I do my best to accommodate requests for crisis visits, this may not always be possible. In the event that you are in crisis or have a psychiatric emergency, you may do the following: (1) go

to the nearest emergency room, (2) call 9-11, (3) call Sonoma County Psychiatric Emergency Services at (707) 576-8181.

In the event that I am away for an extended period of time (e.g., vacation, conference) and it is clear to you and/or me that you may need extra support during that time, I can provide you with the name/contact information of a colleague.

Contact in Public & Social Media

In the event we see each other in public, I will not initiate contact with you. Please note that this is not because I don't want to say hello, but instead, it is intended to protect your privacy. You may, however, initiate contact with me to say hello. This is a standard practice among therapists.

Although potential and current clients might conduct online searches about my practice, I generally do not look up clients on search engines or other social networking sites (e.g., Google, YouTube, Facebook) unless a client requests that I do so and it is clinically relevant or, if in this therapist's professional opinion, doing so is clinically indicated. Also, in order to protect your privacy, I do not communicate with clients on websites (e.g., Linked-In or Google+).

Confidentiality

In general, communications between client and therapist are protected by state and federal law and are kept confidential. In most cases I will obtain from you written authorization before disclosing any information about your care. The information below summarizes issues related to confidentiality, including exceptions to confidentiality. If you have any questions or concerns, I encourage you to bring them up with me so you may discuss them together. I do participate in consultation group and names and identifying qualities will be changed to preserve confidentiality.

HIPAA and Generalized Consent

See the *HIPAA Notice of Privacy Practices* form for information pertaining to your *protected health information* (PHI) and its disclosure.

Legal Exceptions to Confidentiality

There are legal exceptions to confidentiality that you must know about:

1. **Safety emergencies (self-harm/suicide, harm to others/homicide):** In the event that I believe you pose a threat to your own safety or the safety of another identified person, I am required to take protective action, which may include breaching confidentiality (e.g., notifying law enforcement, warning others) in order to protect you or the intended victim. In general, I will make every effort to enlist your cooperation in these circumstances.
2. **Treatment emergencies:** In the event that an emergency situation arises for you and I am contacted by other healthcare professionals and asked to share relevant information to protect you from immediate harm and provide you with appropriate treatment, your therapist is permitted by law to do so.
3. **Mandated reporting of child abuse:** Therapists are mandated reporters. As a mandated reporter, I am required by law to report to the appropriate authorities (e.g., Child Protective Services, law enforcement) any *reasonable suspicion* of child abuse (i.e.,

sexual abuse, physical abuse, emotional abuse, neglect, and exploitation) that I hear about about in my professional capacity. Child sexual exploitation includes knowledge I receive in my professional capacity about an adult accessing pornography involving minors.

4. Mandated reporting of elder & dependent adult abuse: As a mandated reporter, I am required by law to report to the appropriate authorities (e.g., Adult Protective Services, law enforcement) any *reasonable suspicion* of elder and dependent adult abuse that he/she hears about in his/her professional capacity.

Any breach of confidentiality made according to the above legal exceptions to confidentiality will be made to the minimal extent necessary—that is, I will share the least amount of information in order to meet legal obligation.

Client Authorized Disclosures

If you wish for information about your psychotherapy to be released to a third party, I will ask you to sign a written authorization to do so. In this authorization, you may restrict what information you want to be released and may revoke the authorization at any time.

Fees

I ask that psychotherapy fees be paid at the end of each session, unless we agree to another arrangement. Fees may be paid in cash, by check, or credit card.

Psychotherapy

Fees for initial intake and subsequent psychotherapy sessions will be established at the start of therapy. Lisa Grace, LMFT agrees to the contracted rates set forth by insurance carriers in which I am an in-network provider. A limited number of sliding-scale psychotherapy slots are available.

Annual Fee Adjustment

Fees for services may increase annually at the beginning of the year. In the event that this occurs, I will discuss this with you at least one month in advance.

Insurance Reimbursement

I accept insurance payment two ways:

1. *As an Out-of-Network Provider:* Some insurance plans, particularly PPOs, provide out-of-network benefits to members. This means that your insurance provider will pay for services provided by a clinician who is not on their network panel. In this case, we will bill you directly at the standard fee and provide you with a monthly written receipt (called a “Super Bill”) that you may use to seek reimbursement from your insurance provider. If you have health insurance and hope to be reimbursed, it is important that you find out exactly what services your policy covers for “out-of-network providers.”

2. *As an In-Network Provider:* I am an in-network provider on a number of insurance panels. information on insurance plans I currently take, please see my website. Should you decide to use your mental health (sometimes called “behavioral health”) insurance benefit for psychotherapy, please be aware of the following:

1. Typically, insurance carriers require clinicians to provide a diagnosis, information regarding symptoms associated with that diagnosis, and how therapy will address those symptoms to insurance carriers.
2. You are responsible for verifying and understanding the limits of your insurance coverage, as well as any copayments, coinsurance, or deductibles.
3. You are responsible for any and all fees not reimbursed by the insurance plan.
4. As a contracted, in-network provider on your insurance plan, we have agreed to a specified fee for our services and will bill the plan on your behalf.
5. You must pay all copayments, coinsurance, or deductibles, if applicable, at the time of service, unless otherwise arranged.
6. Your insurance carrier will not pay for sessions missed or cancelled within 24 hours (see *Cancellation Policy* below). You are therefore responsible for paying the contracted fee we would normally collect from your insurance carrier plus any part you normally pay (i.e., copayments or coinsurance).
7. By signing the *Informed Consent Signature Page* below, you authorize me to release information (including identifying and diagnostic information) needed to authorize sessions, process claims, request additional sessions, or satisfy the insurance provider's quality review.
8. By signing the *Informed Consent Signature Page* below, you authorize insurance payments to be made to me.

Cancellation Policy

A 24-hour notice is required for cancellation of a psychotherapy session. If you fail to provide 24 hour notice or do not show up for your session, you are responsible for payment of the session fee, unless you were not able to attend because of a true emergency (e.g., car trouble, sudden death in family, etc.) or illness. If you miss two scheduled sessions without notice therapeutic services may be terminated.

Ending Psychotherapy

Ending psychotherapy can be an important part of one's psychotherapy process—a time to reflect on gains, honor feelings about ending the therapeutic relationship, and look toward the future. For this reason, when you decide to terminate psychotherapy, I encourage you to give yourself the time to fully process this important ending by allowing yourself enough time to do so. Clients often find that one to two sessions is not adequate to fully integrate and resolve the therapeutic work. Termination is a key process and will involve important conversations between you I to maximize your therapeutic experience.

Informed Consent Signature Page

Your signature below indicates you have read and understood the above information in the Practice Policies & Informed Consent form and agree to its terms. **If you are paying out-of-pocket or plan to use “out-of-network” insurance benefits** for services, please complete the first box below only. **If you are using insurance benefits**, please only complete the second box below. **If you are a minor**, please complete the third box below with your parent/guardian, and either the first or second box.

For Fee-for-Service/Out-of-Network Clients: *I agree to begin psychotherapy. I agree to the terms outlined above. I*

_____ agree to pay the fee of \$ _____ per session

Client’s signature ~ Consent Date

Client’s signature ~ Consent Date

Check this box if you have insurance that covers “out-of-network” providers and you would like a monthly statement to submit to you insurance carrier.

For Clients Using Insurance Benefits: *I agree to begin psychotherapy. I understand the terms outlined above. I understand the terms of my mental health/behavioral health benefits through my insurance carrier. I understand my therapist will bill my insurance carrier. I have an annual deductible of \$___ for which I understand I am responsible. I have a co-pay of ___ for which I understand I am responsible for at the time of each session. If I am not able to make my co-pay, I understand that a payment plan can be arranged with my therapist*

Client’s printed name

Client’s printed name Parent’s/guardian’s printed name

Client’s signature ~ Consent Date

Parent’s/guardian’s signature ~ Consent Date