

NORTH STATE COUNSELING

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Informed Consent and Practice Policies

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 _____ (Therapist Name) is a/an:

- | | |
|---|---|
| <input type="checkbox"/> Licensed Marriage and Family Therapist | <input type="checkbox"/> Licensed Clinical Social Worker |
| <input type="checkbox"/> Licensed Professional Clinical Counselor | <input type="checkbox"/> Licensed Psychologist |
| <input type="checkbox"/> Registered Psychologist* | <input type="checkbox"/> Psychological Assistant* |
| <input type="checkbox"/> Associate Clinical Social Worker* | <input type="checkbox"/> Associate Professional Clinical Counselor* |
| <input type="checkbox"/> Associate Marriage and Family Therapist* | <input type="checkbox"/> Marriage and Family Therapist Trainee* |
| <input type="checkbox"/> Professional Clinical Counselor Trainee* | |

* If your therapist is an Associate Marriage and Family Therapist, Marriage and Family Therapist Trainee, Associate Clinical Social Worker, Psychological Assistant, Registered Psychologist, Associate Professional Clinical Counselor or Professional Clinical Counselor Trainee, his/her practice is conducted under the supervision of a licensed mental health professional. The clinical supervisor's name, license type and license number are listed below:

Name of Clinical Supervisor

License Type

License Number

Information About This Practice

The name of this practice is: North State Counseling (DBA)

The individual therapist who operate this practice is:

Raechel Lynne Callejo

Licensed Marriage and Family Therapist

#119641

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with your therapist.

About the Therapy Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

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. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Your therapist will work with you to develop an effective treatment plan. Over the course of therapy, your therapist will attempt to evaluate whether the therapy provided is beneficial to you. Your feedback and input is an important part of this process. It is the goal of your therapist to assist you in effectively addressing your problems and concerns. However, 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.

Fees and Insurance

The fee for service is \$120 per individual therapy session.

The fee for service is \$120 per conjoint (marital /family) therapy session.

The fee for service is \$25 per group therapy session.

The fee for service is \$150 per 1.5-2 hour Brainspotting Session

Individual Sessions and conjoint (marital /family) sessions are approximately 53 minutes in length.

Your fee for service if different than above: _____

A \$10.00 service charge will be charged for any checks returned for any reason for special handling.

Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure. Please inform your therapist if you wish to utilize health insurance to pay for services. If your therapist/provider is a contracted provider for your insurance company, your

therapist/provider will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist/provider is happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with your therapist.

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.

Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

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 him or 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.

Minors and Confidentiality

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. **(See Consent to Treat a Minor form)**

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. If you are late for a session, you may lose some of that session time. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hours in advance of your appointment. Cancellations and re-scheduled session will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. Please understand that your insurance company will not pay for missed or cancelled sessions.

Therapist Availability/Emergencies

You are welcome to phone your therapist in between sessions. However, as a general rule, it is our belief that important issues are better addressed within regularly scheduled sessions. However, in the event that you are out of town, sick or need additional support, phone/Telehealth sessions are available. 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 the therapist's normal workdays 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. **In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.**

Suicide Preventions Lifeline: 1-800-273-8255

24-hr mental health: 530-225-5252

Mercy Hospital: 530-225-6000

One SAFE Place: 530-244-0117

Alex Project: Text "Listen" to 741741

Mobile Crisis Unit: 530-238-7133

Shasta Regional: 530-244-5400

Good News Rescue Mission: 530-241-5754

Social Media and Telecommunication

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it. Additionally, therapists do not solicit reviews on social media or other sites as this compromises your confidentiality as well. Therapists with North State Counseling kindly request that you refrain from posting reviews of individual therapists or the practice as a whole.

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Electronic Communication

Sensitive, clinical information is to be discussed over the phone or in-person as deemed appropriate by the therapist. For appropriate e-mail or text communication therapist will respond to your e-mail or text within 24 hours. Potential risks of using electronic communication may include, but are not limited to; inadvertent sending of an e-mail or text containing confidential information to the wrong recipient, theft or loss of the computer, laptop or mobile device storing confidential information, and interception by an unauthorized third party through an unsecured network. E-mail messages may contain viruses or other defects and it is your responsibility to ensure that it is virus-free. In addition, e-mail or text communication may become part of the clinical record. You may be charged for time the therapist spends reading and responding e-mail or text messages.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:

- (1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
- (2) All existing confidentiality protections are equally applicable.
- (3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.
- (4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.
- (5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

CONTACT PREFERENCES FORM

Your therapist may need to communicate with you by telephone or other means. Please indicate your preferences by initialing/completing one or more of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

My therapist may call me on my home phone. My home phone number is: () _____

My therapist may call me on my cell phone. My cell phone number is: () _____

My therapist may send a text message to my cell phone.

My therapist may call me at work. My work phone number is: () _____

My therapist may communicate with me by e-mail. My e-mail address is:

My therapist may send a fax to me. My fax number is: () _____

My therapist may send mail to me at my home address. My home address is:

My therapist may send mail to me at my work address. My work address is:

My therapist may send text message appointment reminders to my cell phone listed above.

My therapist may send e-mail appointment reminders to the e-mail listed above.

Client Name: _____

Client Signature: _____ Date: _____

Therapist: _____ Date: _____

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. Ending relationships can be difficult; Therefore, it is important to have a termination process in order to achieve some closure. 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. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

Legal Disputes

If, for any reason, I am required to participate in a legal dispute, the party responsible for my participation agrees to reimburse me at the rate of \$120/hour for time spent testifying, being in attendance at hearings, or any case-related costs. Additional fees will be incurred for preparing reports, telephoning, and travel time.

Where to File A Complaint

As of July 1, 2020, mental health providers are required to provide this notice with information on where a client can file a complaint about a counselor. The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of Marriage and Family Therapists. You may contact the Board online at www.bbs.ca.gov, or by calling (916)574-7830.

Your signature indicates that you have read this agreement for services carefully and understand its contents (7 pages).

Please ask your therapist to address any questions or concerns that you have about this information before you sign.

Name of Patient or Representative

Relationship to Client

Signature

Date

Therapist/License

Date