Dear New Client:

Welcome. Many people start psychotherapy because they want to feel better, but they may not know very much about what therapy truly is or how it works. Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you are experiencing. There are many different methods I may use to help you overcome the problems you wish to address. In order for therapy to be most successful, you will have to work on what we talk about both during sessions and throughout the week.

Psychotherapy is a process of growth and healing through self-awareness, discovery, and self-acceptance. It is at times painful, exciting, frightening, reassuring, sad, and happy. When successful it leaves one feeling more whole, more at peace, more one with humanity, more productive, and more one with one’s own humanity.

Psychotherapy can be a long journey. The more you put into it, the deeper you are willing to delve, the more you will get out of it. It is important to remember that you are not alone in this process. It is important to be as open and honest with me as possible. This is especially true around issues within the client-therapist relationship itself. Any feelings you have toward me – anger, disappointment, betrayal, longing – should become part of the therapeutic focus. The feelings that come up for you in your relationship with me mirror those that arise in your relationships outside of therapy. Therefore, our relationship is the best device we have to help you improve your other relationships and gain insight into who you are.

The remainder of this packet describes some of your rights and my policies. If you have questions about your rights or these policies feel free to ask me at any time. The “Agreement” details the conditions under which I see clients. Please sign the copy I retain, and supply the information requested on the attached questionnaire

AGREEMENT TO BE SEEN FOR THERAPY

**(Please read carefully)**

THERAPIST I am a California licensed clinical psychologist, PSY 30104. As part of providing you with the best possible care, I consult on a regular basis with other licensed clinical psychologists. Your personal identifiable information will be disguised as much as possible to assure your privacy.

# FEES The full fee for a fifty-minute therapy session is $225. Clients not paying full fee and/or when appropriate, will have their fees reassessed every 2-4 months with the possibility of changes based on your financial situation. I accept payment by check, or cash. Checks should be made out to *Dr. Christopher Marquart.* Crisis intervention between appointments will be charged in 15min increments and according to my full fee of $225. If circumstances call for an in-person therapy session at a treatment facility or hospital the fee is $300 for a fifty-minute session, which includes travel time. All services (document preparation, subpoenas, consultation, phone calls, paperwork, retaining counsel, testimony, travel time, etc.) provided for court or legal purposes will be billed at an hourly rate of $300.

PAYMENT OF FEES: You are responsible for payment of all fees charged. Payment is due at the end of every session and checks should be made payable to *Dr. Christopher Marquart*. If you do not pay your session fees within 30 days of service, then the balance will be forwarded to a collection agency.

INSURANCE I accept Medicare. If you are using your Medicare or insurance benefits, you are hereby giving permission for me to contact your insurance carrier and to bill your insurance for services. In order to use your PPO insurance benefits, I will provide you with a superbill at the end of the month to submit for reimbursement. I are considered an out-of-network provider and each plan and insurance carrier has different reimbursement rates. It is your responsibility to check with your insurance carrier to determine what their coverage is for out-of-network providers.

CANCELLATION POLICY: When you enter into therapy, a specific treatment hour is set aside for you, and you only. This is your hour whether you use it or not. Therefore, I ask that, by-and-large, you pay for that hour whether you use it or not. You are responsible for payment of sessions when you give less than 24-hours cancellation notice. Please be advised that Medicare does not pay for missed sessions thus you will be responsible for the full session fee if you do not provide 24-hour notice of cancellation.

MEDICATION: I will make an appropriate referral to a psychiatrist should medication be a useful adjunct to your psychotherapeutic work. I do not provide these services.

TELEPHONE CALLS: I do my best to return calls within 24 hours. I only return phone calls if you leave me a voicemail stating that you would like me to call you back. I do not return “missed calls**.” If you are unable to reach me in an emergency and need immediate attention, please call 911 or the emergency room of the nearest hospital.** Crisis intervention between appointments will be charged in 15min increments and according to my full fee of $225. Under special circumstance you may also schedule a full session using the telephone. By signing this consent, you are hereby also consenting to future telehealth.

VACATIONS: I generally take between three to four weeks of vacation during the year. I will give you advance notice as to when I will be away.

COURSE OF TREATMENT: Psychotherapy, which addresses underlying emotional processes, often takes some time. Painful emotions may be evoked, and you might experience periods of distress. These may be a normal part of the therapy, but it is important that you discuss any such reactions with me.

This type of therapy is also a cooperative endeavor, requiring knowledge and skill on the part of the therapist, and both the client’s effort and his or her ability to tolerate painful emotional experiences. For these reasons, it is not possible to predict how much benefit you will derive from therapy.

CONFIDENTIALITY: I pledge to do everything in my power to protect your confidentiality. Everything about your therapy, from what you say to me to the very fact that you come to see me, is known as “Protected Health Information” (PHI) and is guarded by state and federal laws. As a rule, I will not release any information about you to any party without a consent form signed by you.

You should be aware, however, that the same state and federal laws that guard your confidentiality also include certain exceptions. These include:

* For Treatment: in case of emergency I may need to disclose PHI to another health practitioner to facilitate acute treatment.
* For Payment: Normally, I will ask you to sign a release of information for us to bill a third-party payer. However, I do reserve the right to use a collection agency, as a last resort, without your written consent.
* For Consultation: I am a licensed clinical psychologist. As part of ongoing and excellent care I consult with other psychologists.
* As Required by Law: Please be aware that under California state law I am a mandated reporter of child, elder, and dependent adult abuse. I am also required to take action to protect any threatened third party, action that may include notifying the police and warning the third party directly. Finally, if I believe you to be acutely suicidal, I may act to institute involuntary hospitalization.
* Lawsuits: Please be aware that if you initiate a lawsuit in which you claim compensation for mental suffering you may forfeit your rights to confidentiality. Please discuss this possibility thoroughly with an attorney and with me before you initiate any such action.

# RIGHTS REGARDING YOUR PHI

You have the following legal rights regarding your PHI in our records

* The Right to Inspect and Copy: With certain exceptions, you have the right to inspect and copy your treatment and billing records. This request must be made in writing and I am obligated to respond to your request within five working days. If I believe that viewing your records would be detrimental to you, I may opt to give you a detailed summary, as outlined by law. If you are not content with this, you have a right to a second opinion by another licensed health care professional. I will comply with that second opinion.
* The Right to Request Amendment: If you believe that my records are in error or incomplete, you have the right to request (again, in writing) that I amend or correct those records. If I believe the records to be accurate, I have the right to decline your request, in which case you have the right to submit a Statement of Disagreement, which will be included in your records
* The Right to Request Restrictions: You have the right to request additional, specific restrictions on how and to whom I communicate PHI. I will honor these requests except as mandated by law, as indicated above.
* The Right to Request Confidential Communications: You have the right to request specific ways in which I communicate with you. For example, you may not wish me to leave messages on your answering machine, call you on your cell phone, etc. Please discuss this with me.
* The Right to a Paper Copy of this Notice: You may request a copy of this notice at any time.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with the federal government. Contact:

Office of Civil Rights (Room 515F)

US Department of Health and Human Services

200 Independence Avenue, S.W.

Washington, D.C., 20201

Should you have any other complaints about the service you receive contact:

### Board of Psychology

1422 Howe Avenue, Suite 22

Sacramento, CA 95835-3236

Your signature on the Therapist’s Copy indicates that you understand and accept the above stated conditions relating to your treatment.

**THERAPIT’S COPY**

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#### By signing the bottom of this agreement I am agreeing to pay the amount of $\_\_\_\_\_\_\_ per session for ongoing therapy sessions; or am authorizing Medicare or other insurance to be charged for my sessions. If paying less than full fee, I understand that this fee may be reassessed every 2-4 months based on my financial situation.

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1422 Howe Avenue, Suite 22

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Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed \_\_\_\_\_\_\_\_\_\_\_ Date