Shannon Sampson, MA LMFT
Licensed Marriage & Family Therapist (MFC 51965)
858.255.1452

PATIENT INFORMATION AND CONSENT TO TREATMENT

Welcome to my practice. I am committed to giving you the best care possible. The following information is being provided to acquaint you further with the policies and procedures of this counseling office:

1. THE THERAPEUTIC PROCESS & TREATMENT CONCERNS:

Therapy is most effective when both client and therapist make a commitment to the therapeutic relationship and process. Through mutual commitment, the therapist and client create a relationship in which there is trust, respect, safety, and an open exploration of the client's thoughts, feelings and experiences. Within the safety of the therapeutic relationship, change becomes possible.

Psychotherapy can have both risks and benefits. The counseling process may include discussions of your personal challenges and difficulties, which can lead to uncomfortable feelings such as sadness, anger, guilt and frustration. However, counseling has also been shown to have many benefits. It can often lead to better overall well-being, interpersonal relationships, academic/work performance, and solutions to specific problems. However, there is no assurance of these benefits. If you have any questions or concerns about the negative effects of treatment, please discuss them with me.

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. You may discontinue therapy at any time. However, it is a good idea to plan for your termination, in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals. In certain circumstances, i.e. if you are not making progress in treatment or in case of a discovered conflict of interest, either of us may elect to initiate a discussion of your treatment alternatives.

2. APPOINTMENTS:

Services are by appointment only. When I set an appointment with you, that time is reserved exclusively for you. **If you need to cancel your appointment, I require a minimum of 24-hours notice; otherwise, you are responsible for full payment for the missed appointment.** Messages may be left on my voicemail or sent via email where the time and date of your message will be accurately recorded.

If you cancel your appointment with less than 24 hours notice, or if you miss your appointment, payment in full for the missed session is required at your rescheduled

appointment, or within 30 days, whichever occurs first.

Counseling sessions last 50 minutes. Please be punctual. If you are late for any reason, you will receive the remainder of your scheduled time. This is necessary so that I can see following clients at their scheduled times. You will, however, be required to pay the full fee.

3. THERAPIST AVAILABILITY/EMERGENCIES:

It is my policy to limit contact between sessions (whether via phone or email) to discussions of scheduling. I feel this is important because therapeutic issues are better addressed within regularly scheduled sessions. Any discussions lasting longer than 15 minutes will require a full session fee.

You may leave a message for me at any time on my confidential voicemail, (858) 255-1452. If you would like a return 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 normal workdays, within 24-48 hours. I do not check messages on weekends or over holiday breaks.

If you have an urgent need to speak with me, please indicate that fact in your message and follow any instructions that are provided by my voicemail. **If you are experiencing a crisis and in need of immediate assistance, please call 911 to request emergency assistance, head to your nearest emergency room, or call the San Diego County Access and Crisis Line at (888) 724- 7240.** As a private practitioner who treats many clients, I am not available for crisis interventions between sessions. If you feel your condition is too acute to be treated on a weekly outpatient basis, please let me know. We can discuss adding appointments or referral to a practitioner or clinic more suited to your needs.

4. COUNSELING CHARGES:

Counseling fees are set prior to your first appointment. **You are fully responsible for payment of all services rendered, at the time of service.** Fees are to be paid at the beginning of your session. You may pay with cash, check, or credit card. Checks should be made out to “Shannon Sampson, MFT.” A penalty fee of $20.00 will be assessed on all checks returned by the bank for any reason. Re-payment of the returned check must be made by cash.

I do not bill insurance. My contract is with you, not your insurance company. I require full payment at the time of service. You may bill your insurance directly. If you should choose this route, be sure to ask me for a receipt of payment. In giving you a receipt, I am making no guarantees that your insurance will reimburse you.

5. UNPAID BALANCES:

A late charge of $20.00 will be assessed if payment is not received within 30 days. If a balance remains unpaid, I reserve the right to secure an attorney or collections agency to secure payment. Any accounts with a past due balance of 60 days or more will be handed over to a collection agency and will incur a $50.00 processing fee.

6. CLIENT'S RIGHTS

At any time, clients may question and/or refuse therapeutic procedures and methods, or request information about the process and course of therapy. Clients are also assured of confidentiality, except under particular situations that are specified on the attached Confidentiality Statement. For specific need to exchange information such as with your physician, I will discuss this with you and provide a "Release of Information" form in order for you to give your permission to exchange the information.

I am dedicated to you and your counseling needs, and appreciate your cooperation in these matters. Should you have any questions or concerns regarding these policies, feel free to address them with me.

Please sign below to indicate: "I have read the above policies, and I understand and agree to comply with them. "

Client Name (print): ____

Client Signature: ____

Date: __________________________

If Minor, Consenting Adult Name (print): ______________________________

Consenting Adult Signature: ____

Date: ___________________________

If Minor, Consenting Adult Name (print): ______________________________

Consenting Adult Signature: ____

Date: ____________________________

CONFIDENTIALTY STATEMENT

All communication between you and me will be held in strict confidence, unless you provide written permission to release information about your treatment, or unless exceptions arise which, by law, require or permit additional action on my behalf.

If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all persons who participated in the treatment with you provide their written authorization to release.

I utilize a "no-secrets" policy when conducting family therapy. This means that if you participate in family therapy, I may use information obtained in an individual session with me when working with other members of your family if I feel it is necessary.**The following circumstances are exceptions to confidentiality and are required by law to report:**

A. When I receive communication of a threat of bodily injury or harm against yourself or toward a specific person. I will take steps to protect those in danger. This may include notifying law enforcement personnel and the intended victim, contacting a friend or relative, or hospitalization.

B. When there is knowledge or reasonable suspicion of abuse or neglect to a child, elder, or dependent adult

C. If the issue of your mental status is raised in a court of law, the information in your case file can be subpoenaed and I can be compelled to testify about your treatment and your mental health. I will not release information to the court without your permission unless I am compelled to do so by a court order. Note: if you are, or expect to be involved in a court action, it is my policy not to testify or otherwise participate in any legal proceeding unless I am legally compelled to do so.

In order to provide the best possible treatment, I regularly consult with other professionals about my cases. No identifying information will be given in these consultations.

It is important to remember that electronic communication such as e-mail, faxes, and cell phone calls are not secure. Please keep this in mind if you choose to communicate with me using these methods. Please note: my office phone is a cell phone; as with any electronic communication, there is a small risk of interception by a third party.

Your signature below constitutes full acknowledgement of this potential risk to your confidentiality, and a waiver of any liability on the part of Shannon Sampson MFT for any breach of confidentiality resulting from electronic communication. If you have any questions about confidentiality, please discuss them with me at any time.

I have read and understood the above information regarding confidentiality. I agree to disclose personal information with these exceptions in mind.

______________________ ________________________________ _______________

Client Signature **Consenting Adult Signature** (if applicable) **Date**

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FINANCIAL AGREEMENT

Pre-determined Fee per 50-minute session: $125

Party Responsible for Payment (circle): SELF or OTHER

If OTHER, Name: ____

Relationship to Client: ____________________________________

Address: ____________________________ City: ______________ State: ______

Home Phone: _____________________ Cell Phone: ______________________

I understand that at the end of each appointment, I will pay the agreed rate for psychotherapy services. If I do not give 24-hour notice of cancellation or if I miss my appointment, I will pay in full at my next scheduled appointment, or within 30 days, whichever comes first.

Guarantor Agreement: *I certify that the above information is true and correct.*

____ _________________

Adult Client/Consenting Party's Signature **Date**

____ ________________

Therapist Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at (858) 255-1452. If you have any questions about my Notice of Privacy Practices, please contact me at:

Shannon Sampson, MFT
5665 Oberlin Drive, Suite 201
San Diego, CA 92121

OR

Shannon Sampson, MFT
5230 Carroll Canyon Road, Suite 314,
San Diego, CA 92121

I acknowledge receipt of the Notice of Privacy Practices of Shannon Sampson, MFT.

Client Signature: ______________________________________ **Date:** _________________