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# Randall B. Davis, M.F.T.

## Disclosure Statement & Agreement For Services

**Introduction**

This document is intended to provide important information to you regarding your treatment. Please read this document and the Notice of Privacy Practices carefully and feel free to ask me any questions that you may have regarding its contents.

**Information about Your Therapist**

I am a licensed Marriage and Family Therapist, and you are welcome to ask any questions regarding my professional background, experience, education, special interests, and professional orientation. You are also free to ask additional questions at any time as they arise.

**Fees and Insurance**

The fee for service is $150 per therapy session. Individual sessions and conjoint (marital or family) sessions are 45 minutes in length. Fees are payable at the time that services are rendered. I do not work directly with insurance companies and I am not a member of any insurance preferred panels. Although I am happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will reimburse you for the services provided to you. Please discuss any questions or concerns that you may have about this with me. If for some reason you find that you are unable to continue paying for your therapy, please inform me and I 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. 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. (In addition, your therapist will not disclose information communicated privately to him or her by one family member, to any other family member without written permission.) There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child, dependent adult or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

**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.

**Coordination of Care with your Primary Care Physician**

Release of basic clinical information to your Primary Care Physician will greatly assist in coordinating your treatment. Please select whether I may contact your Primary Care Physician. If you check yes, I will ask you to sign a release of information to allow this communication. ❒ **Yes** ❒ **No**

**Appointment Scheduling and Cancellation Policies**

Sessions are scheduled to occur at a frequency determined by your treatment plan. I will suggest a frequency of therapy depending on the nature and severity of your concerns. 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 hrs. in advance of your appointment. If you do not provide at least 24 hours notice in advance, you are responsible for payment of $75 for the missed session. Please understand that your insurance company will not reimburse you for missed or late cancelled sessions.

**Therapist Availability/Emergencies**

Telephone questions between office visits are welcome. However, I will attempt to keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions. If you find that you need frequent contact between sessions, you and I can discuss your treatment plan and find ways to increase your support systems or change the frequency of your sessions. You may leave a message for me at any time on my confidential voicemail. If you wish me 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 normal workdays (Monday through Friday) generally within 24 hours. 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. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, it is important that you call 911 to request emergency assistance. The emergency services available in your community are equipped to respond to your emergency in a timely manner. You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis:

**Crisis Hotline: (800) 784-2433 or (800) 273-8255**
**Domestic Violence Help: (951) 683-0829**

**Telephone Therapy Informed Consent Checklist:**

Video-Conferencing services, also known as Telemedicine / Telehealth may be used at times when you are out of town between sessions, unable to make your appointment due to illness, or to assist in transition to a new living arrangement. There are some particular issues particular to Teletherapy for you to be aware of and agree to:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for teletherapy services, and nobody will record the session without the permission from the other person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the therapist will explain how to use it.
- You need to use a computer with a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify me 24 hours in advance by phone or email as per the missed appointment policy.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in teletherapy sessions.
- As your therapist, I may determine that due to certain circumstances, teletherapy is no longer appropriate and that we should resume our sessions in-person.

I agree to use Video-Conferencing (Teletherapy) as needed and agree to the above conditions:

❒ **Yes** ❒ **No**

**Therapist Communications**

I may need to communicate with you by telephone, mail, email, text, or other means. There is some level of risk that information in a regular (unencrypted) text message or email could be read by someone other than you. Please let me know if I may communicate with you by any of the following means.

❒ **Yes** ❒ **No** You may call me at my home. My home phone number is:_____
❒ **Yes** ❒ **No** You may call me on my cell phone. My cell phone number is:_____
❒ **Yes** ❒ **No** You may communicate by regular (unencrypted) text message on my cell phone.
❒ **Yes** ❒ **No** You may call me at work. My work phone number is: _____
❒ **Yes** ❒ **No** You may send mail to me at my home address.
❒ **Yes** ❒ **No** You may send mail to me at my work address.
❒ **Yes** ❒ **No** You may communicate by regular (unencrypted) email:_____
❒ **Yes** ❒ **No** You may send a fax to me. My fax number is:_____

**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 to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and patients 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 patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

**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. It is a good idea to plan for your termination, in collaboration with me. We will discuss a plan for termination as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine 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.

Your signature indicates that you have read this agreement and the Notice of Privacy Practices carefully and understand its contents. You understand that fees are payable at the time services are rendered. You understand that you will be billed for missed appointments and late cancellations as previously defined. A copy of this signature is as valid as the original. Please ask me to address any questions or concerns that you have about this information before you sign!

_____ **Date:** _____/_____/_____
**Patient Signature**

_____ **Date:** _____/_____/_____
**Parent or Guardian Signature (if patient is a minor)**

_____ **Date:** _____/_____/_____
**Therapist Signature**