Jonathan Bartlett, MA LMFT

(408) 353- 3791

CONSENT FOR INDIVIDUAL PSYCHOTHERAPY (MINOR)

Today's Date: _____

Client Name: _____

Date of Birth: _____

Introduction

This agreement is intended to provide clients with important information regarding my professional services and business policies. Any questions or concerns regarding the contents of this agreement should be discussed with me prior to signing it.

Therapist Background and Qualifications

I am a licensed Marriage and Family Therapist (MFT) with the State of California Board of Behavioral Sciences (BBS). I received my M.A. degree in Counseling Psychology from JFK University in 2006. I am a clinical member of the California Association of Marriage and Family Therapists (CAMFT).

Confidentiality

The information disclosed by the client is generally confidential and will not be released to any third party without written authorization from the client, except when required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a client makes a serious threat of violence towards a reasonably identifiable victim, or when a client is dangerous to him/herself or the person or property of another.

Records and Record Keeping

I may take notes during sessions, and I will also produce other notes and records regarding your treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Should you request a copy of my records, such a request must be made in writing. I reserve the right, under California law, to provide you with a treatment summary in lieu of actual records. I will maintain your records for ten years following termination of therapy. However, after ten years, your records will be destroyed in a manner that preserves your confidentiality.

Fee and Fee Arrangements

The agreed upon fee for service is **$ _____ per 50-minute session**. You will be notified of any fee adjustment in advance. You are expected to pay for services at the time services are rendered. Cash and checks are accepted. Checks should be made out to: Jonathan Bartlett.

Insurance Information

At your request, I will provide you with a statement for your insurance company so that you may receive reimbursement. The information may include dates of appointment, diagnosis, and a treatment summary. I ask that you pay for your treatment up front. It is my policy to write statements for reimbursements on a monthly basis.

Cancellation Policy

You are responsible for payment of the agreed upon fee for any missed session(s). You are also responsible for payment of the agreed upon fee for any session(s) for which you fail to give at least 24 hours notice of cancellation. Cancellation notice should be left on my voice mail (408) 353-3791.

Therapist Availability

My office is equipped with a confidential voice mail system that allows you to leave a message at any time. I will make every effort to return calls within 24 hours, but I cannot guarantee calls will be returned immediately. I am unable to provide 24-hour crisis service. To speak with a crisis counselor you may call the 24 hour Suicide/Crisis Hotline at: (408) 279-3312. In the event that you are feeling unsafe or require immediate medical or psychiatric assistance, you should call 911, or go to the nearest emergency room.

Termination of Therapy

In our initial sessions, you and I should pay careful attention to whether or not we feel comfortable working together. In addition, part of my responsibility includes assessing if the services I am offering can be helpful to you. If you have any questions about my work or procedures, please discuss them with me whenever they arise. If your doubts persist, you are free to seek an opinion from another mental health professional or to terminate therapy at any time.

I reserve the right to terminate therapy at my discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, a client's needs are outside of my scope of competence or practice, or a client is not making adequate progress in therapy. If either of us decides to terminate therapy, I will generally recommend that you participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both of us an opportunity to reflect on the work that has been done. I will also attempt to ensure a smooth transition to another therapist by offering referrals.

Acknowledgment

By signing below, I/we are entering into this counseling services contract with full understanding, participation, and consent. By signing below, the client and parents/guardians (if client is under 18 years old) consent for the client to receive counseling services and state they have read and agree to the above policies and procedures.

Client Guardian(s) Signature/Date _____

Client Guardian(s) Signature/Date _____

Client Signature/Date _____