Kathleen Mates-Youngman M.A. LMFT
THERAPIST | AUTHOR | SPEAKER

Individual, Couple, and Family Therapist
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INFORMED CONSENT FOR TREATMENT

Introduction

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 any questions that you may have regarding its contents.

Information about Your Therapist

Kathleen Mates-Youngman M.A., LMFT, will be providing me with therapy services. These services may consist of assessments, interviews, therapy sessions, and review of records. At an appropriate time, I will discuss my professional background with you and provide you with information regarding my experience, education, special interests, and professional orientation. You are free to ask questions at any time about my professional background, experience and orientation. _____(initials)

Fees and Insurance

The fee for service is $150.00, and sessions are approximately 50 minutes in length. **Payment/co-payment is to be paid at the beginning of the session in order to allow the entire time to be spent on therapy.** Payments can be made in cash, by check, or by credit card with a 3% service fee added. Please inform me if you wish to utilize health insurance to pay for services. If I am a contracted provider for your insurance company, or billing your insurance company for you as a non-contracted provider, I will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments, co-insurance, 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 I am happy to assist your efforts to seek insurance reimbursement, I am 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 me.

It is important to understand that it is the client's responsibility to ensure that his/her account balance is paid in full. If the account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I do have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, such costs will be included in the claim. In such a situation, the only information I will release regarding the treatment is the client name, the nature of services provided, and the amount due. 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. _____(initials)

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, I 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 I utilize a " no-secrets" policy when conducting family ormarital/couples therapy.** This means that if you participate in family, and/or marital/couples therapy, I am permitted to use information obtained in an individual session that you may have had with me, when working with other members of your family.

There are exceptions to confidentiality. For examples, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person or when a client 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 client that the FBI sought or obtained the items under the Act.

Also, I may at times consult with other professionals as part of ongoing clinical consultations. At all times, I will protect the privacy of my client(s) by concealing his/her name and other identifying characteristics. _____(initials)

Minors and Confidentiality

Communications between myself and clients 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, in the exercise of my own professional judgment, I may discuss the treatment progress of a minor client with the parent or caretaker. Clients who are minors and their parents are urged to discuss with me any questions or concerns that they have on this topic. _____(initials)

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. I 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. In order to cancel or reschedule an appointment, your are expected to notify me at least **24 hours** in advance of your appointment. **FOR MISSED SESSIONS OR SESSIONS CANCELLED WITH LESS THAN 24 HOURS NOTICE, YOU ARE RESPONSIBLE FOR FULL PAYMENT OF THE TIME RESERVED FOR YOU.** Please understand that your insurance company will not pay for missed or cancelled sessions. _____(initials

Therapist Availability/Emergencies

Telephone consultations 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.

You may leave a message for me at any time on my confidential voicemail at (949) 225-7434. If you wish for 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) within 24 hours. I am not able to return calls after 10 P.M.

If you have an urgent need to speak with me, please indicate that fact in your message and follow any instructions that are provided in my voicemail message.

In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis:

National Suicide Prevention Lifeline (800) 273-8255

Orange County Domestic Violence Services (714) 935-7956

Orangewood Children's Foundation (Youth Shelter) (714) 547-2981 _____(initials)

Therapist Communications

I may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking any of the options below that you approve of. Please be sure to inform me if you do not wish to be contacted at a particular time or place, or by a particular means.

____My therapist may call me at my home. My home phone number is ( )_____

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

____My therapist may text scheduling information to me.

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

____My therapist may send mail to me at my home address.

____My therapist may send mail to me at my work address.

____My therapist may communicate with me by email. My email address is_____

____My therapist may send a fax to me. My fax number is_____

Emergency Contact:

_____ _____

name phone number

_____

relationship

Personal Questions

1. Do you ever feel guilty about your drinking habits? ____ yes ___ no

2. Have you ever attempted to reduce your alcohol intake? ___ yes ___ no

3. Have you been arrested for your drinking behavior? ___ yes ___ no

4. Do you use illegal drugs? ___ yes ___ no

5. Do you ever take prescription drugs in a way that is not medically advised? ___ yes ___ no

6. Have you ever been arrested for your behavior while on drugs? ___ yes ___ no

7. Do you currently feel suicidal? ___yes ___ no

8. Have you been suicidal in the past? ___ yes ___ no

9. Have you ever attempted suicide or to seriously harm yourself? ___yes ___ no

10. Do you currently have the intent to harm, seriously hurt, or kill another individual?___ yes ___ no

11. Have you ever seriously harmed, purposefully, another individual? ___ yes ___ no

12. Do you feel safe in your current relationship? ___ yes ___ no

13. Is there a partner from a previous relationship who is making you feel unsafe now?___ yes ___ no

14. Have you ever been sexually abused? ___ yes ___ no

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 your therapist and the specifics of your situation, I will provide recommendations to you regarding you treatment. I believe that therapists and clients 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.

It is important to be aware that there are benefits as will as risks associated with therapy. Potential risks include a lack of improvement, disruption in one's life following therapeutic changes, and emotional pain related to exploration of difficult experiences. Potential benefits include improved personal relationships, clarification of one's personal values and goals, and an improved ability to behave in new and meaningful ways. _____(initials)

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 your therapist. I 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 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 for services carefully, understand its contents, and freely acknowledge your willingness to undergo the evaluation and treatment performed by Kathleen Mates-Youngman M.A., LMFT.Please feel free to address with me any questions or concerns that you have about this information before you sign!

_____ _____

Client Name (printed) Client Signature Date

_____ _____

Client Name (printed) Client Signature Date

_____

Client Address

_____

Kathleen Mates-Youngman M.A. LMFT Date

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