

OFFICE POLICIES & GENERAL INFORMATION AGREEMENT FOR PSYCHOTHERAPY SERVICES

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law.

California law and professional ethics requires therapists to maintain confidentiality except for (1) where there is reasonable of suspicion of child abuse, dependent adult abuse and elder abuse and (2) "Tarasoff" situations in which a client threatens to do harm to a reasonably well identified victim.

If a client threatens to harm him/herself, confidentiality may be broken in order to protect the client.

You may be asked or required by your medical insurance carrier or HMP/PPO/EAP to sign a release of confidential information in order to process the claims. Ms. Bost has no control or knowledge over what insurance companies do with the information she submits or who has access to that information.

If you are involved in litigation, you may be asked to sign a release for psychotherapy records. If the court subpoenas therapy records, California law precludes confidentiality.

Clients under 18 do not have complete confidentiality from their parents.

Communication regarding therapy to other licensed health care providers requires a client's signature. I may seek out consultation with colleagues without asking permission, but your identity remains anonymous, and confidentiality is fully maintained. From time to time I make teaching contributions using disguised client material.

FEES: Individual clients are expected to pay the standard fee of _____ per 50 minute session and couples are expected to pay _____ per 50 minute session or _____ for a 75 minute or 100 minute session. Fees for evenings after 6pm or the weekend may cost more than the standard fee. Payment either by cash, check, or credit card is expected at the time services are rendered. A \$25 charge is made for any check returned to Ms. Bost as non-payable for any reason.

INSURANCE REIMBURSEMENT: It is your responsibility to verify the specifics of your insurance coverage, the benefits your insurance policy and of any changes in your benefits. Your insurance is a contract between you and your insurance company. Ms. Bost is not party to that contract. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance company. Unless agreed on differently, Ms. Bost will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement if you choose.

CANCELLATIONS: Since scheduling of an appointment involves the reservation of time space, specifically for you, a minimum of 48 hours (2 days) notice is required for rescheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

TELEPHONE, EMAIL AND EMERGENCY PROCEDURES: It is the consensus of mental health professionals that reliable and valid psychotherapy is always conducted in face to face setting, so that non-verbal communications will be taken into consideration. However, there may be times or circumstances under which telephone contact may have limited value, such as: Brief, between-session contact calls or emails, long distance communication when either party is out of town or otherwise unavailable, and long distance communication when therapy seems near its natural termination or either party relocates making regular standard sessions impossible.

If you need to contact Ms. Bost between sessions, please leave a message on her voice mail (310.317.1615) and your call will be returned as soon as possible. Ms. Bost checks her message a few times a day, unless she is out of town. If you need to talk to someone right away, you can call the Police (911). On weekends or holidays she may return the call the next business day.

THE PROCESS OF THERAPY/EVALUATION: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits; however, requires effort on your part. Psychotherapy requires your active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Ms. Bost will ask for your feedback and views on your therapy, its progress, and other aspects of therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with certain situations. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc... or experiencing anxiety, depression, insomnia, etc... Ms. Bost may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, Ms. Bost is likely to draw on various psychological approaches according, in part, to the problem that is being treated and her assessment of what will best benefit you.

DUAL RELATIONSHIPS: Therapy never involves sexual or business relationships or any other dual relationship that impairs Ms. Bost’s objectivity, clinical judgment, or therapeutic effectiveness.

I have read the Agreement and Office Policies and General Information carefully. I understand them and agree to comply with them:

Client Name (Print)	Date	Signature
---------------------	------	-----------

Client Name (Print)	Date	Signature
---------------------	------	-----------

Sheila K. Bost, MFT	Date	Signature
---------------------	------	-----------

Sheila K. Bost, LMFT, MFC 47175
12304 Santa Monica Blvd.
Suite 213
Los Angeles, CA 90025
.317.1615
transform@sheilakbost.com

www.sheilakbost.com

28720 Canwood St.
Suite 204
Agoura Hills, CA 91301
310.317.1615
transform@sheilakbost.com