Beth Fiance, MA, LMFT

Licensed Marriage & Family Therapist, #115170

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Informed Consent and Office Policies

Welcome to my office!
This informed consent agreement authorizes you and me, Beth Fiance, MA, LMFT, to enter into a psychotherapeutic relationship.

CONFIDENTIALITY: The information disclosed by you in psychotherapy (including your patient records), is generally confidential and will not be released to any third party without your written authorization, except when required or permitted by law.

EXCEPTIONS: Exceptions to confidentiality include, but are not limited to reporting child, elder, and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identified victim, or when a patient is dangerous to him/herself or the person or property of another. Disclosure may also be required if you are involved in a legal proceeding initiated by you or filed against you. If you place you mental status at issue in litigation, the other party may have the right to obtain the psychotherapy records and/or testimony by your therapist. In couple and family therapy, confidentiality and privilege do not apply between the couple or among family members since I have a no secrets policy. I will not release any records to any outside party unless I am authorized to do so by all adult parties who were part of the family therapy, couple therapy, or other treatment that involved more than one adult client.

ELECTRONIC COMMUNICATION: To protect your confidentiality, my computer is equipped with a firewall, a virus protection and a password. It is important to be aware that I will do everything possible to insure your privacy through our electronic communication, but please notify me in writing if you decide to avoid or limit in any way the use of emails, texts, cell phone calls and phone messages. If you communicate through any of these means I will assume that you have made an informed decision and will view it as your agreement to communicate electronically.

HEALTH INSURANCE EXCEPTION TO CONFIDENTIALITY: Although I am not on any insurance panels, if you chose to bill your own insurance company disclosure of confidential information will be required by your health insurance carrier in order to

process the claims. If you instruct me to provide you with a statement to bill your insurance, only the minimum necessary information will be communicated. I have no control over, or knowledge of what insurance companies do with the information I submit or who has access to this information once I release it to you.

FEES: Our agreed upon rate is $225 for a 50-minute session. Payment is due at the time of service and may be paid by credit card, check or cash. Phone and video sessions are charged at the same rate.

Reading of reports, consultation with other professionals, release of information, and reading records will be charged at the same rate with your prior knowledge and agreement.

CANCELLATION POLICY: The time that we agree to meet is set aside and saved for you. If you have to cancel for any reason, a 24-hour notice is required to avoid being charged the full fee for your missed appointment. THIS IS A FIRM POLICY.

OUT OF SESSION CONTACT AND EMERGENCIES: If you have an urgent matter that cannot wait until your next scheduled appointment, call my voicemail or text and I will do everything I can to call you back or see you as soon as possible. Voicemails, emails and texts are checked during normal business hours and days. If you have a true emergency, please call 911.

I have read the Informed Consent and Office Policies carefully. I understand them and agree to comply with them:

Client's Name (print) _____

Client's Signature _____

Date _____

Psychotherapist's Name (print) _____

Psychotherapist's Signature _____

Date _____