Rebecca G. Kahane, LMFT

Licensed Marriage & Family Therapist
License #MFC 37382

DISCLOSURE STATEMENT & AGREEMENT FOR SERVICES

Please Note: This document provides important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents. Please initial or sign where indicated.

Information About Your Therapist: Your therapist, Rebecca Kahane, is a licensed Marriage & Family Therapist in the State of California. Her license number is MFC 37382.

The Therapy Process: It is your therapist's intention to provide services that will help you reach your goals. Based upon the information that you provide to your therapist and the specifics of your situation; your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Participating in therapy can result in several benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Also, it may result in your experiencing considerable discomfort. Change will sometimes be easy and swift, but more often it will be slow and frustrating. Remembering and resolving significant life events in therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended.

I understand and acknowledge that, due to the varying nature and severity of problems and the individuality of each patient, my therapist is unable to predict the length of my therapy or to guarantee a specific outcome or result.

Initials: _____

Treatment Philosophy: During the initial evaluation period, you and your provider will clarify together the nature of the problems for which you are seeking treatment, define some reasonable treatment goals, and develop a treatment plan that will help you achieve those goals. You are expected to be compliant with the agreed-upon treatment plan between sessions and keep your appointments. Research has shown that, often times, brief, time limited therapy focusing on specific goals results in more rapid reduction of symptoms and improvement in patient functioning. The treatment plan may include attending support groups, reading selected materials, and/or completing specific written or verbal assignments.

Client's Rights

1. Confidentiality: You have the right to a confidential relationship with your therapist. Within certain legal limits (see section 3 below), information revealed by you during the course of therapy will be kept completely confidential and will not be revealed to any person without your written permission.

    a. Couples or family therapy: 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 such information. *As well, it is important that you know that your therapist utilizes a*

"confidentiality" policy when conducting marital/couples therapy. This means that if you participate in marital/couples therapy, your therapist will not use information obtained in an individual session that you have had with her, when working with the couple. Both partners must agree before setting up an individual session that confidential information would be withheld. If both partners cannot agree on this condition, no individual sessions will be conducted.

b. 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 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.

Initials: _____

2. Content of your records: You have the right to know the content of your records at any time and I have the right to provide you with the complete records or a summary of their content.

Initials: _____

3. If you ask me and provide written consent, I can release any part of your records on file to any person you specify. I will tell you when you make your request whether or not I think releasing that information to that agency or person might be harmful to you.

Initials: _____

4. Under certain legally defined situations, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:
   - Revealing to me active child abuse or neglect: If an alleged perpetrator is in contact with minors and there is a *reasonable suspicion* that he/she may still be abusing minors;
   - Abuse of a dependent adult or elder adult: If active physical, sexual or financial abuse of a dependent adult or an elder is taking place;
   - Serious threats of death/harm: If you seriously threaten harm or death to another person, I am required to warn the intended victim and notify the appropriate law enforcement agencies;
   - Court-ordered treatment: If you are in therapy or are being tested by order of the court, the results of the treatment or tests ordered must be revealed to that court;
   - Subpoena: If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in that subpoena. If you are in a lawsuit, the opposing side may subpoena your therapy records;
   - Federal law: 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.

Initials: _____

5. You have the right to ask questions about any of the procedures used in the course of your therapy.

Initials: _____

6. Should you choose not to enter therapy with your therapist, they will provide you with names of other qualified professionals whose services you might prefer.

Initials: _____

7. You have the right to terminate therapy with your therapist at any time without any financial, legal or moral obligations other than those you've already incurred. Your therapist has the right to terminate therapy with you under the following conditions:

   - When your therapist believes that therapy is no longer beneficial to you;
   - When your therapist believes that another professional will better serve you;
   - When you have not paid for the last two sessions unless special arrangements have been made with your therapist;
   - When you have failed to show up for your last two therapy sessions without a 24-hour notice to your therapist;
   - If your therapist determines during the first three sessions that they cannot help you, they will assist you in finding someone qualified. If your therapist has written consent, they will provide that professional with information they request;
   - When you fail to cooperate with the proposed treatment or fail to take your medications as directed by your physician.

   If any of these situations apply, your therapist will provide written notice to you of their decision and will give you the names of several therapists for your future counseling needs.

   Initials: _____

8. <u>Your right to a good faith estimate:</u> Pursuant to the "No Surprises Act," you have the right to receive a "Good Faith Estimate" explaining how much your mental health care is anticipated to cost. Under the law, your therapist must give patients who don't have insurance or who are not using insurance an estimate of the expected charges for psychotherapy services, if the patient requests such information. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services.

   a. You can ask your therapist for a Good Faith Estimate before you schedule a service. To request a Good Faith Estimate, please contact your therapist in writing at ***therapy@rebeccakahanemft.com***.

   b. If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.

   c. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call (800) 985-3059.

   Initials: _____

Office Policies

Fees and Insurance: Prior to scheduling your session, you were quoted a fee for either an individual or a conjoint session. Individual sessions and conjoint (couples or family) sessions are 50 minutes in length unless otherwise agreed. Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure.

Since your therapist is not a contracted provider for any insurance companies, your agreement with your therapist is to pay for the session rate at the time of services. Please inform your therapist if you wish to utilize your health insurance for reimbursement directly from the insurance company. Your therapist will provide you with a Super-bill in order to receive reimbursement. 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 your therapist is happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any concerns that you may have about this with your therapist.

If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

Initials: _____

Medicare Provider Status
Please be aware that I am an Opted-Out provider. This means I am not contracted with Medicare. Medicare will not reimburse you for the cost of my services. If you are a Medicare beneficiary, we will need to enter into a private contract for therapy services in order for me to treat you.

Initials: _____

Appointment Scheduling and Cancellation Policies: While sessions are typically scheduled to occur one time per week at the same time and day, if possible, for 50 minutes, your therapist may suggest a different amount of therapy or session length depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. **To cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hours in advance of your appointment via email, text or phone call. If you do not provide your therapist with at least 24 hours' notice in advance, you are responsible for payment for the missed session.** Please understand that your insurance company will not pay for missed or cancelled sessions.

Session Start and End Time; Prorating: Sessions are expected to start at the agreed-upon time and last 50 minutes. If you are late, your therapist generally will not be able to extend your session time, which may result in you receiving a session that is less than 50 minutes long. Your session will **not** be prorated if you are late; you will be charged the full session fee.

Sessions that go beyond the fifty minutes allotted will be prorated to the nearest quarter hour, unless you have made prior arrangements with your therapist.

Initials: _____

Therapist Availability/Emergencies: Your therapist offers telephone consultations between office visits if doing so is clinically indicated. Your therapist will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions.

You may leave a message for your therapist at any time on her confidential voicemail at *310-925-0607*. If you wish your therapist 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. You are also welcome to text your

therapist at ***310-925-0607***or email her at ***therapy@rebeccakahanemft.com***; however, texting and emailing are not guaranteed to be confidential. Please make your choice accordingly.

You should be aware that your therapist is generally available to return phone calls within 24 hours. Your therapist is not able to return phone calls after 9:00 p.m. Your therapist is not available to return phone calls on Saturdays or Sundays, unless there is a clinical emergency. Please indicate such an emergency in the message you leave and, if provided, follow any instructions that are provided by your therapist's 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.*

Initials: _____

Telephone Time: Should you need to contact your therapist between sessions, you can do so by calling the telephone number listed above and leaving a message. She will return your call as soon as she is able. **Please note that calls which last longer than ten minutes will be charged at your regular fee.**

Initials: _____

Therapist Communications: Your therapist may need to communicate with you by telephone, e-mail, mail, or other means. Please indicate your preference by so indicating on the Intake Form you have filled out. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

Initials: _____

Additional Charges: Your therapist is not agreeable to appearing in court or providing testimony by way of deposition or declaration. Specifically, your therapist is client's treating mental health care professional and will not testify in an expert capacity or as an advocate in any legal proceeding client may be or become involved in. However, in the event your therapist is compelled or ordered by the court to provide records or testimony, you hereby agree to pay your therapist for the following:

- If copies of any of your records must be made, pursuant to your authorization or order of the court, such copies shall be made at the cost of $.25 per page and preparation of said copies will be billed at $200.00 per hour.

- In the event your therapist is subpoenaed to testify in court or deposition or requested to produce records or provide a summary of treatment, your therapist will be paid $300.00 per hour for her preparation time, travel time from portal to portal, wait time, time spent providing testimony as well as time spent reviewing the deposition transcript.

- If these fees are not paid by the attorneys involved in your case, you, the client, will be responsible to pay the fees within 30 days of the provided invoice. If these fees have not been collected within 30 days, your therapist retains the right to collect these fees in Small Claims Court.

Initials: _____

Grievances: You have the right to submit a grievance to your provider at any time to register a complaint about your care. Such a grievance shall be sent to your provider at the address below.

Initials: _____

By signing this form, Client confirms that he/she/they has/have read this Disclosure Statement and Agreement for Services carefully and understands its contents. Client further acknowledges that he/she/they has/have had the opportunity to address any questions or concerns that they have about this document with their therapist.

_____	_____
Name (*printed*)	Date of Birth
_____	_____
Signature	Date
_____	_____
Name (*printed*)	Date of Birth
_____	_____
Signature	Date