THERAPEUTIC CONTRACT

RESTORE & REBUILD COUNSELING

The Therapy Process

Participating in therapy can result in a number of 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 and may result in you 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. The therapeutic process incorporates several techniques, including, but not limited to: insight, interpretation, cognitive/behavioral restructuring, teaching and modeling communication skills, drawing, sand tray, parts work, experiential exercises, reframing, dream analysis, educating about individual and family patterns, relaxation techniques, and various pencil and paper tests.

Client's Rights

1. You have the right to a confidential relationship with your therapist. (See exceptions to confidentiality under "**Confidentiality Statement**" below.)

2. You have the right to know the content of your records. Upon your written request your therapist may provide you either with a copy of your complete record or a summary of the content.

3. Upon the written request of involved clients your therapist may release any part of your records, to the person you specify. Your therapist will tell you when you make your request whether or not he/she thinks releasing that information to the specified agency or person would be in your best interest.

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

5. You, or your therapist, have the right to terminate therapy at any time without any financial, legal, or moral obligations other than those you have already incurred. The following conditions may be reasons for termination:
    - When therapy is no longer beneficial to you.
    - When another professional would better serve you. Your therapist will provide you with other professional referrals.
    - When you have not paid for the last two sessions, unless special arrangements have been made between you and your therapist.
    - When you have failed to show up for your last two therapy sessions.

Consent for Treatment

I authorize my therapist to administer psychotherapeutic examinations, diagnostic procedures, and/or treatment during the course of my care. I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I have read and fully understand this Consent for Treatment. I agree to enter a therapeutic relationship with_____.

Therapist's Name/Title

I have read and understand the above statements about "The Therapy Process," "Client's Rights," and "Consent for Treatment."

_____	_____	_____
Name of Client (or parent/guardian if client is a minor)	Signature of Client (or parent/ guardian if client is a minor)	Date
_____	_____	_____
Name of Client (Print)	Signature of Client	Date

Confidentiality Statement

All information revealed by a client during the course of therapy will be kept confidential and will not be revealed to any agency or other person without the client's written permission. Under certain legally defined situations your therapist is required to reveal information you tell him/her during the course of your therapy with your written consent.

Confidentiality of client information will not be maintained under the following conditions:

1. The therapist has a reasonable suspicion of child abuse. Child abuse is defined as:
    - Physical Abuse
    - Sexual Abuse
    - Neglect
    - Endangerment - In California, child endangerment includes any incidents of Domestic Violence (DV) occurring when children are anywhere in the home or within the vicinity of the DV. The law considers exposing a child to DV "endangers the person or health of a child" and produces "mental suffering" for the child.

    All suspected abuse will be reported to the appropriate authorities.
2. The therapist has knowledge of elder abuse or dependent adult abuse. All knowledge of abuse will be reported to the appropriate authorities.
3. The client threatens suicide, physical harm to self, or appears to be gravely disabled. The therapist will inform client's support system or report to appropriate authorities to provide safety for the client. (See "**Duty to Warn**" below.)
4. The therapist has information that his/her client has threatened homicide or other physical harm to another person. The therapist is required by law to warn the intended victim and notify the appropriate law enforcement agencies.

If you are being seen in couples/family therapy, your therapist may have a "no secrets policy." Please ask your therapist if this applicable in your situation.

Duty to Warn

Confidentiality and privileged communication remain rights of all clients according to state law. However, courts have held that if an individual intends to harm him- or herself or is gravely disabled, it is the therapist's duty to warn appropriate individuals of such intentions. Those warned may include a variety of individuals and is up to the therapist's discretion. Such individuals may include the following:

- Family members, caregivers, and/or friends of the client
- Law enforcement officials
- Local psychiatric emergency team members

Before breaching confidentiality the therapist will take all possible steps to first share that intention with the client. Every effort will be made to prevent any such breach of confidentiality.

I have read the above "Confidentiality Statement" and "Duty to Warn" and I understand my therapist's legal and ethical responsibility to make such decisions where necessary.

_____	_____	_____
Name of Client (or parent/guardian if client is a minor)	Signature of Client (or parent/ guardian if client is a minor)	Date
_____	_____	_____
Name of Client (Print)	Signature of Client	Date

Office Policies

Sessions: The standard session time is 50 minutes, unless other arrangements are made with your therapist.

Contact Information: Your therapist is available between sessions at his/her confidential phone/voice mail. Your therapist will return your call when able; however your therapist is **NOT** an emergency contact (see "**Emergency Procedure**" below).

Cancellation: Since an appointment reserves time specifically for you, a minimum of 24 hours notice is required for rescheduling or cancellation of a scheduled appointment. A $25 fee will be charged for missed sessions without such notification or late cancellations. Most insurance companies do not reimburse for sessions missed.

Texts and Emails: Your therapist is available to be reached by text message and by email. However, your therapist does not address therapy issues between sessions by text or by email. Texts and emails are used only for scheduling or conveying other basic information, not for counseling.

Emergency Procedure: In the event of a mental health emergency, **please call 911 or go to your nearest emergency room for care.** Please also call your therapist's confidential phone/voice mail when possible in order to keep your therapist informed.

Financial Agreement

You are expected to pay for services at the time they are rendered unless other arrangements have been made. Please notify your therapist if any problem arises regarding your ability to make timely payment.

I understand that I will make payment at the time of the therapy appointment, unless other arrangements have been made with my therapist. I understand that I can leave therapy at any time and that I have no financial, legal or moral obligation to complete the treatment. I agree to pay for completed therapy sessions, and for sessions I miss without providing 24-hour notice, as outlined in the above "**Office Policies.**"

Upon entering a therapeutic relationship with a Restore & Rebuild therapist, I understand that my financial information will become privy to the accountant for Restore & Rebuild Counseling. All financial information will be held in strictest confidence by the accountant. This may include credit card information and/or information that I carry on my personal check such as name, address, phone number, fee/payment amount, and financial institution.

Insurance Reimbursement

Clients who carry insurance benefits that reimburse for mental health treatment should remember that therapeutic services are rendered and charged to the client and not to the insurance company. If you plan to use insurance reimbursements, upon your request your therapist will provide you with a superbill for you to file with your insurance company.

I understand that by using insurance benefits I authorize my therapist, if necessary, to disclose required information to my insurance company to assist in processing the claim. Required information may be as follows: assessment, diagnosis, treatment plan, treatment costs, dates of service, type of therapy, etc.

"Good Faith Estimate"

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least one business day before your medical service or item. You can also ask your health care provider for a Good Faith Estimate before you schedule an item or service.
- 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.
- For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-800-985-3059.

Acknowledgment of Receipt of Privacy Practices

I have received a copy of Restore & Rebuild Counseling's "Notice of Privacy Practices" with an effective date of November 17, 2014. **I have read, understand, and agree to the above "Office Policies," "Financial Agreement," "Good Faith Estimate," and "Insurance Reimbursement." I acknowledge receipt of privacy practices.**

Name of Client (or parent/guardian if client is a minor)	Signature of Client (or parent/ guardian if client is a minor)	Date
Name of Client (Print)	Signature of Client	Date