Lilach Harris MFT
1330 Orange Ave #311
San Diego, CA 92118
619-241-6006

Introduction

This document is intended to provide _____ important information 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.

Information about Your Therapist

At an appropriate time, your therapist will discuss her professional background with you and provide you with information regarding her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience, and professional orientation. Your therapist is a licensed Marriage and Family Therapist in CA.

Information About This Practice

The individual Therapist who operates this practice is Lilach Harris MFC 43461

Fees

The fee for service is $120 per individual/conjoint therapy session. Mediation fee is $125 per party.
All sessions are 50 minutes in length, unless special arrangements have been made in advance, payment is due for professional services at the time of service. The first session is longer and is about 90 minutes.
Please inform your therapist is you wish to utilize health insurance to pay for services. If your therapist is a contracted provider for insurance company, your therapist will discuss the procedure for billing your insurance. The amount of reimbursement and the amount of any co-payment 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.
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 consider any options that may be available to you at that time.

Confidentiality

All communication between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you practice 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 written authorization to relations. In addition, your therapist will not disclose information communicated privately to him or her by one family member, to any other family member without written permission).
There are exceptions to confidentiality. For example therapists are required to reports suspected child abuse or elder abuse. Therapist may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, federal law knows 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 patient that the FBI sought or obtained the items under the act.
All communication 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 martial 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. However, it is important that you know that your therapist utilizes a "no secrets" policy when conducting family or marital/couples therapy. This means that if you participate in family and or marital/couple therapy, your therapist is permitted to use information obtained in an individual session that you may have had with her, when working with other members of your family.

Minors and confidentiality

Communication 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 disclose the treatment of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to disclose any questions or concerns that they have on this topic with their therapist.

Appointment scheduling and cancellation policy

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of the problem. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hours in advance. If you do not provide your therapist with at least 24 hours notice in advance, you are responsible for payment for the missed session. (Insurance will not pay for missed or cancelled appointments).

Therapist availability

Telephone consultations between office visits are welcomed. However, your therapist will attempt to keep those brief due to our belief that important issues are better addressed within regularly scheduled sessions. You may leave your therapist a confidential message on her voice mail. If you wish your therapist to call you back please be sure to leave your name and phone number along with a brief message concerning the nature of the call. Non-urgent calls will be returned during normal working hours (Monday through Friday) within 24 hours. If you have an urgent need to speak to your therapist, please indicate that fact in the message and follow any instructions that are provided by your therapist's voice mail. 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:
Mental Health Crisis Hotline: (800) 479-3339
Domestic Violence Help: (619) 234-3164.
Youth shelter: (858) 270-8213 or (619) 687-1080

Therapist communication

Your therapist may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices below. 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.

My therapist may call me at my home phone. My home number is _____
My therapist may call me on my cell phone. My cell phone is _____
My therapist may call me at work. My work phone is _____
My therapist may send mail to my home address _____
My therapist may communicate with me by email. My email address is _____

About the therapy process

It is your therapist's 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, your therapist will provide recommendations to you regarding your treatment. I believe that therapist and patient(s) 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.

Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict he length of therapy or to guarantee outcome or result.

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. Your therapist 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 your therapist determines that you are not benefiting from treatment, either of you 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 and understand its content.

Name of Patient

Signature Date