Amy Pesceone
MFT, CHT, License #MFC39739
info@amypesceone.com

PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

Amy Pesceone, MFT

Welcome to my practice. This Agreement contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so we can discuss them at our meeting. When you sign this paperwork, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation period, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. ***Therapy involves* a *large commitment* of *time, money, and energy,* so *you should be very careful about the therapist you select.*** If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS AND CANCELLATIONS

I normally conduct an evaluation that will last from 1 to 3 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will schedule a **45 minute session** per week (**30 minutes for minors**) at a time we agree on. A scheduled appointment means that time is reserved only for you. **If an appointment is missed or cancelled with less than 24 hours notice, you will be billed for your session**. Your health plan does not cover payment for missed appointments; therefore, you are responsible for payment in full.

Initial here ________

PROFESSIONAL FEES, BILLING and PAYMENT

My hourly fee is $150. **Co-payments and deductible must be paid at the time services are rendered.** Please prepare your check ahead of time, so that we can make maximum use of our session. **Your insurance is billed as a courtesy, but you remain personally responsible for the fee should it not be covered by insurance**. If you are not eligible at the time services are rendered, you are responsible for full payment. I will verify health plan/insurance coverage and policy limits, and will be paid directly by the insurance company. You will be responsible for any applicable deductibles and co-payments. Please note that if fees are not paid, I reserve the right to seek legal action. (Only your name and treatment type will be provided.)

Initial here ________

Please discuss with me when financial circumstances make it difficult to pay your bill on a weekly basis as **large balances may result in straining both you and me personally, and in our work together**. In circumstances of unusual hardship, I may be willing to negotiate a fee adjustment. My sliding scale fee is $100. In addition to weekly appointments, I will break down the cost of other services such as report writing, telephone conversations lasting over 10 minutes, preparation of records such as for court or a letter for your employer. My policy is to refrain from involvement in any custody disputes.

CONTACTING ME
Unfortunately, I am often not immediately available by telephone. I am in the Los Alamitos office from 10 to 6 on Tuesdays and Wednesdays. I am in the Hermosa Beach office on Thursdays from 9:30 to 6:00. I am out of the office on Mondays and Fridays. I do not take calls when I am with a client. My telephone is answered by a confidential voice mail that I monitor frequently. I will make every effort to call you back within the same day, but it may take as long as 24 hours.
In an emergency, leave a message according to the instructions on the voice message and your call will be returned. Please do this for true emergencies only. There will be a charge for telephone consultations over 10minutes.

MINORS
If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that for teenagers, they agree to give up access to your records. If they agree, I will provide them only general information about our work together, unless I feel that there is a high risk that you will seriously harm yourself or someone else. In this case I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible and do my best to handle any Objections you may have when I am prepared to discuss.

CONFIDENTIALITY All information between provider and patient is held **strictly confidential** unless:

1. The client authorizes release of information with his/her signature.
2. The client presents a physical danger to self.
3. The client presents a danger to others.
4. Child/elder abuse/neglect are suspected.

In the latter two cases, I am required by law to inform potential victims and legal authorities so that protective measures can be taken.

- Confidentiality may be waived if you request that I testify in court or make your mental or emotional status an issue in a lawsuit. Also, most insurance companies also require that I reveal some clinical information. Your signature on the client information form constitutes your permission to release this information. Please ask me if you have any questions about what your particular insurance company may require.

CONSENT FOR TREATMENT
I further authorize and request that my treating provider carry out mental health examinations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement.

I understand and agree* to *all* of *the above information.

____
Client - Printed name

X_____________________________________ ***X***______________________
Client – Signature/Guardian ***Date***

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Dear Clients,

If you are undergoing therapy, we require your credit card information to keep in our file and your authorization to use it in the case of an outstanding balance. This can happen in the following circumstances:

1) You are using your insurance and your insurance does not cover the therapy.
2) You have a late Cancellation or No-Show Charges.
3) You are being seen for an issue that is not covered by the Insurance.

If you chose not to fill this, please be advised that you will not be able to schedule additional sessions until your balance is cleared.

If you are paying out of pocket for therapy, please be advised that we require full payment at the time of the appointment.

Thank you,

Amy Pesceone, MFT

Patient Name: ___________________________________ Card Holder Name: ________________________________

Type of card: Visa______ MasterCard______ Discover______ Amex______

Card Number __________ - __________ - __________ - __________ CVV Number ___________________

A 3-digit number in reverse italics usually on the Back of the credit card (except Amex)

Expiration Date _____________________

Card Holders Billing Address for Credit Card Statements

____

Street City State Zip

I ____ authorize Amy Pesceone MFT, to use my credit card in the case of an outstanding balance on my account.

Card Holder Signature ____ Date _____________________

901 N. Pacific Coast Hwy #200
Redondo Beach, CA 90277
(310) 480-8362

4281 Katella Ave #122
Los Alamitos, CA 90720
(562) 489-4046

PLEASE PRINT

CONFIDENTIAL CLIENT INFORMATION

Date:________________

Name:____
First Middle Last

Address:____
Number Street City State Zip

Mailing Address (If Different):_______________________________________
Number Street City State Zip

Home Phone: ( )__________________________ Cell phone( )_______________________
OK to Call? o Yes o No o Yes o No
OK to Leave Message? o Yes o No o Yes o No

Date of Birth:___________________________ Email:___________________________________ Ok to email? Yes no

Marital Status: Single Married Divorced Separated Widowed Partner

Client's Employer:____ o Full Time o Part Time

Emergency contact_______________________________ cell phone__________________________

Insurance Carrier:____ Type of ins. PPO EAP POS HMO

Customer Service Phone #: (usually on front of card)____

"Mental Health" phone #, or "Provider phone #"-*: (usually on back of card)____________________________

I.D.Number on card_______________________________________ Group Number: __________________________________

Claims Address:____

Policy Holder: Name:____ Policy holder's date of birth:__________________

Policy holder's address- Same as above? Yes No Address:____

Policy holder's **Employer**:____

Relationship of patient to insured: Self Spouse Partner Child Other_________________________________

RESPONSIBLE PARTY INFORMATION (If other than patient)

Name:____

Address:____

Home Phone: ( )______________________ Cell Phone: ( )_______________________________________

Relationship to Patient:__________________________

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other informaton necessary to process all claims, and I authorize payment of medical benefits to Amy Pesceone, MFT for all services provided.

SIGNED:X____ DATE:____________________