

Anne MacDavid, MS, LMFT

Licensed Marriage and Family Therapist
MFC 42748

Post Office Box 80884 29839 Santa Margarita Pkwy 515 E. First St, Suite D
Rancho Santa Margarita, CA 92688 Bldg 300, Suite 2 Tustin, CA 92780
(949) 322-2331 www.orangecountyhealing.com email: annewmft@cox.net

Disclosure Statement and Agreement for Services

Welcome to the office of Anne W. MacDavid. This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me regarding any questions you may have. In an attempt to establish a smoothly running office system and a professional relationship with my clients, I have developed the following policies and procedures. I ask that you read and sign this information sheet in order to ensure your understanding and willingness to abide by the policies as established. Please do not hesitate to ask questions and thank you in advance for your cooperation. The requested information becomes part of your file and is *confidential*. Please print.

Name _____ Home Phone () _____

Referred by: _____ email _____

Names of **all participants** in therapy _____

Home Address _____ May I call you at home? _____
(number and street)

(city) _____ (state) _____ (zip code) _____
Date of Birth _____ Cell Phone () _____

Employed by _____ Business Phone () _____
May I call you at work? _____

Business Address _____
(number and street)
(city) _____ (state) _____ (zip code) _____

Social Security Number: _____ Driver's License Number: _____

In case of EMERGENCY contact:

Name: _____ relationship _____

Address: _____
(number and street)

(city) _____ (state) _____ (zip code) _____
Home Phone: _____ Business Phone: _____ Cell Phone: _____

Fees

The fee for service is \$120 per individual or family therapy session. Individual Sessions and conjoint sessions are approximately 50 minutes in length. Fees are payable at the time that services are rendered. Phone consultation time is billable in 15 minute intervals. I would appreciate it if you would fill out your check before session begins, made payable to "Anne MacDavid", so as to maximize your valuable session time. If you are paying with cash, please

have the exact amount. If for some reason you find that you are unable to continue paying for your therapy, you should inform me. I will help you consider any options that may be available to you at that time. *Initial ()*

Confidentiality

The psychotherapeutic relationship and all client records are confidential. No client information will be given out without your written permission with the following exceptions:

- **ABUSE:** If you tell me that you have been mentally, physically or sexually abused as a minor, elder or a dependent adult, or if you indicate that you have in any way been involved in, or have knowledge of anyone being involved in any of the above referenced abuses to a minor, an elder or a dependent adult, I am required by California law to report this information to appropriate legal agencies.
- **THREAT OF HARM TO SELF OR ANOTHER:** Section 1024 of the Evidence Code of the State of California requires me to break confidentiality if I have reasonable cause to believe that a client is in such mental or emotional condition as to be dangerous to her/himself or to the person or property of another.
- **COURT ORDER:** Upon advice of counsel, I will comply with any lawful court order to release information about your contact here.
- **PATRIOT ACT:** In addition, a federal law known as The Patriot Act of 2001 requires therapist (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 communications between you and your therapist will be held in strictest confidence unless you provide written permission to release information about your treatment.

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. **However, it is important that you know 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/couples 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, if she feels it will be helpful. Please feel free to ask me about the “no secrets” policy and how it may apply to you. *Initial ()*

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 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. *Initial ()*

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a success outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hours in advance of your appointment. My voice mail handles calls 24 hours/day when I am not in the office. *If you do not provide your therapist with at least 24 hours notice in advance, you are responsible for payment of the missed session, and will be billed.* *Initial ()*

Therapist Availability/Emergencies

Telephone consultations between office visits are welcome. However, I will attempt to keep those contacts brief due to my 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. 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 should be aware that your therapist is generally available to return phone calls within

approximately two hours. Your therapist may not be available to return phone calls after eight P.M. or on Saturdays or Sundays.

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 be aware of the following resources that are available in the local community to assist individuals who are in crisis:

Crisis Hotline: (800) SUICIDE
Youth Shelter: (949) 494-4311
Domestic Violence Help: (800) 799-SAFE
Rape Crisis: (714) 957-2737

About the Therapy Process

It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. I 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 client, I am unable to predict the length of your therapy or to guarantee a specific 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. I 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 contents. If you would like a copy of this agreement, please ask your therapist.

Signature _____

Date _____

Signature _____

Date _____

Credit Card Authorization

(note: all information stored in locked, confidential files)

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

In case of late cancellations and/or no-shows for scheduled sessions, you will be charged the full session fee.

I, _____, am authorizing Anne MacDavid, M.S., M.F.T. the use of (print name)

my credit card in the event that I do not notify Ms. MacDavid of my inability to attend a scheduled therapy appointment and/or do not cancel my appointment at least 24 hours in advance as agreed to in her Financial Arrangement policies. This method of payment may also used to satisfy unpaid balances on accounts.

Card Type (circle one): Visa MasterCard Discover

Card #: _____ Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code (3-digit code on back by signature line) _____

Billing Address: _____
(Street, City, State & Zip)

Signature: _____ Date: _____