Family Consultation Services

Dear Client

Welcome! We are very glad to have you as a client at Family Consultation Services. We will do everything possible to merit the confidence you have shown in coming here for professional help. The following information will acquaint you with our established policies and procedures.

Communication

We want to hear from you when you need us. Your call will usually be received by our 24-hour voice mail system. While the counselors do not answer calls during therapy sessions, they will respond to your call as soon as possible. When your call is an emergency, please follow the instructions to contact our answering service who will, in turn, contact your therapist. Remember that emergency calls can also be made by dialing 911. *If the call takes more than a few minutes the therapist will assess a pro-rated charge.*

Appointments…..

When appointments are scheduled, that time is reserved only for you. If you need to change your appointment time, please allow us **twenty-four (24) hours** notification. ***A full session charge is assessed for late cancellations or missed appointments****, unless necessitated by an emergency.*

Financial Arrangements….

Our charges for psychotherapy and counseling are based on current, usual and customary fees for this area. We have agreed that your fee(s) for professional services are $_____ per individual session, $_____per couple/family session, and/or $_____ per group session. When a balance does exist a billing statement will be mailed monthly and prompt payment is expected at that time. Additionally, consultations with other professionals and reports prepared on your behalf will be charged a pro-rated fee. Assessment testing is charged on a per instrument basis. Payment may be made with cash, personal checks, Visa or MasterCard. A **$25 charge is made for any check returned to us as non-payable for any reason.** Accounts over 90 days past due may be sent to collections and additional fees may be applied.

Payment is ***expected*** at the time services are rendered either by Cash, Check, or Credit card.
By signing below and providing my credit card information, I authorize FCS to charge my credit card for session fees in which I do not provide payment in the form of cash or check (unless arrangements have been made with the therapist). Additionally, I authorize charges for missed appointments not cancelled within the 24 hours advanced notice, not showing up for scheduled appointments, returned check fees and amount of check paid, past due amount over 30 days. I understand my credit card will only be used under these circumstances and/or when I have failed to provide payment in another form (i.e. cash or check).

_____	_____	_____
Client Name	Client's Signature	Date
_____	_____	_____
Print Client Name	Client's Signature	Date

Name on Credit Card	
Billing Address for Card	
Credit Card Number	
Expiration Date	CVV (3 Digit code on back):
Credit Card Type	Visa Master Card American Express

2525 Camino del Rio S. Suite 315 San Diego CA 92108 Office: 619-280-3430 Fax: 619-280-5420

Insurance….

We provide assistance in billing your insurance company as a courtesy. Please note we are not contracted with Medicare, Medi-Cal, any medical groups or HMOs. In order to bill your out-of-network insurance we must obtain a copy of your insurance card (front and back). You are responsible for obtaining any pre authorization, paying all deductibles, co pays and any balance remaining after insurance has paid their portion. We are happy to file your insurance claims for you, but due to the wide variations in coverage, payment may be requested from you as services are rendered until it is determined what portion, if any, your insurance will pay. If your insurance denies payment of any service, payment of these services are ultimately your responsibility.

Confidentiality….

Successful therapy requires that you be as honest and open with your therapist as you possibly can. As a safeguard to you and the information that you share with your therapist, the State of California provides a legal privilege which protects the confidentiality of the information that you disclose to your therapist. The fact of your presence in therapy, the verbal disclosures which you make to your therapist, any written or other documentation which you might give to your therapist, and all of your therapist's clinical notes are protected as confidential information. It is important that you understand the legal exceptions to confidentiality and that you know that it is our policy to work only with those clients who irrevocably agree that the right to confidentiality is waived when the client is: imminently a danger to self; imminently a danger to others; and disclosing information regarding suspected child or elder abuse. The client's confidentiality is also waived when the client signs an authorization to release information or when a minor client's legal guardian signs such release. Confidentiality can also be waived when the therapist is served with a Court-ordered subpoena and is advised by professional legal counsel to release the subpoenaed information.

To ensure the highest quality of excellent professional care you deserve, Family Consultation Services therapist meet together regularly for peer consultation. In addition, Marriage and Family Therapy Interns meet in weekly supervision sessions with their supervisors at which time full disclosure of relevant information is required with the supervisor and may also be disclosed during peer consultation sessions.

Appropriate Professional Conduct…

As with any professional relationship, the psychotherapeutic relationship requires high standards of moral, ethical, and appropriate conduct on the part of the psychotherapist. Specifically, any form of sexual intimacy between a therapist and a client is never appropriate. The booklet ***"Therapy Never Includes Sex"*** is available to you upon your request if sexual intimacy has ever occurred between you and a therapist during any previous courses of psychotherapy.
If you have any questions please let us know. Your therapist is happy to discuss any of the above with you in greater detail. As a client, I have read and understand (or have asked for clarification about) the information If presented in this two page form, and consent to treatment within the aforementioned guidelines.

_____	_____
Client Signature	Therapist Signature
_____	_____
Print Name	Print Name
_____	
Client Signature	
_____	_____
Print Name	Date
_____	
Date	

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