Gloria Dahlquist, LMFT

Office Policies & General Information Agreement for

Psychotherapy Services

This form provides you, the client, with information that is additional to that detailed in the Notice of Privacy Practices.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.

WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW: Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to me, Gloria Dahlquist, LMFT, that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony from Gloria Dahlquist, LMFT. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless I am authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client, unless I am required by law to do so. While I will do my best to seek your authorization to release the requested information regarding our psychotherapy from you first, in some situations a judge can order the release of the records of your psychotherapy with me or may order me to testify in regard to our therapeutic work.

CONSULTATION: On occasion, I consult with other professionals regarding my clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained.

EMERGENCY: If there is an emergency during therapy, or in the future after termination, where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on your intake form as your emergency contact.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process claims. With your written consent to bill your insurance for your sessions I provide only the minimum necessary information required by your insurance carrier to submit your claim. I have no control over, or knowledge of, what insurance companies do with the information I submit or who has access to this information. You must be aware that submitting a mental health claim for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies' computers and may be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to hacking and unauthorized access. Medical data has also

been reported to have been legally accessed by law enforcement and other agencies, which also puts you in a vulnerable position.

E–MAILS, CELL PHONES, TEXTS, COMPUTERS, AND FAXES: It is very important to be aware that computers and unencrypted emails, texts, and e-fax communications (which are part of the clinical records) can be rather easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communications. Emails, texts, and e-faxes are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all emails, texts and e-faxes that go through them. While data on my laptop is encrypted, emails, texts and e-faxes are not. It is always a possibility that e-faxes, texts, and emails can be sent erroneously to the wrong address and computers. My laptop is equipped with a firewall, a virus protection and a password, and I back up all confidential information from my computer on a regular basis onto an encrypted hard drive. Also, be aware that phone messages are transcribed and sent to Gloria Dahlquist, LMFT via unencrypted emails. Please notify me if you decide to avoid or limit, in any way, the use of email, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted emails, texts or e-faxes or via phone messages, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and I will honor your desire to communicate on such matters. Please do not use texts, emails, voice mails, or faxes for emergencies.

CLINICAL RECORDS: Both the law and the standards of my profession require that I keep treatment records for at least 6 years and 3 months. Please note that clinically relevant information from emails, texts, and faxes are part of the clinical records. Unless otherwise agreed to be necessary, I will retain clinical records only for as long as mandated by California law or your insurance carrier if I am billing your insurance carrier for you. If you have concerns regarding the treatment records, please discuss them with me. As a client, you have the right to receive a summary of your records at any time, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. Considering all of the above exclusions, if it is still appropriate, and upon your written request, I will release information to any agency/person you specify unless I assesses that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please leave a message on my voicemail at (949) 244-3674 and your call will be returned as soon as possible. I check my messages a few times during the day unless I am out of town or out of cell service. I may provide a contact (licensed provider) for you if I am on vacation. If an emergency arises, indicate it clearly in your message and if you need to talk to someone right away please go to your local emergency room or dial 911. Please do not use email or faxes for emergencies. I do not always check my email or faxes daily.

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fee per session at the end of each session unless other arrangements have been made. Telephone conversations, site visits, writing and reading of reports, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify me if any problems arise during the course of therapy regarding your ability to make timely payments. I do provide the service of billing your insurance carrier for your sessions if you choose to use your insurance to get reimbursed for your sessions. Sometimes the out of network insurance carrier will pay an amount less than my standard fee. Since I am

not contracted with the insurance carrier you are responsible for paying the difference between what the insurance carrier pays and my standard fee. You are responsible for contacting your insurance company before the first session to make an informed decision about using or not using your insurance to pay for your sessions. As was indicated in the section, Health Insurance & Confidentiality of Records, you must be aware that submitting a mental health claim for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are dealt with in psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE:

Participation in therapy can result in several benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your highly active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. I will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. I may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, I will likely draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, cognitive, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. I provide neither custody evaluation recommendation nor medication or prescription recommendation nor legal advice, as these activities do not fall within my scope of practice.

TREATMENT PLANS: Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits.

TERMINATION: As set forth above, after the first couple of meetings, I will assess if I can be of benefit to you. I do not work with clients who, in my opinion, I cannot help. In such a case, if appropriate, I will give you referrals that you can contact. If at any point during psychotherapy I either assess that I am not effective in helping you reach the therapeutic goals or perceived you as non-compliant or non-responsive, and if you are available and/or it is possible and appropriate to do, I will discuss with you the termination of treatment and conduct pre-termination counseling. In such a case, if appropriate and/or necessary, I would give you a couple of referrals that may be of help to you. If you request it and authorize it in writing,

I will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, I will give you a couple of referrals that you may want to contact, and if I have your written consent, I will provide her or him with the essential information needed. You have the right to terminate therapy and communication at any time. If you choose to do so, upon your request and if appropriate and possible, I will provide you with names of other qualified professionals whose services you might prefer.

SOCIAL NETWORKING: I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites can compromise your privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites.

AUDIO OR VIDEO RECORDING: Unless otherwise agreed to by all parties beforehand, there shall be no audio or video recording of therapy sessions, phone calls, or any other services provided by me.

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 day) notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

I have read the above Office Policies and General Information, Agreement for Psychotherapy Services. I understand them and agree to comply with them:

Client's Name (print) _____

Signature _____ Date _____

Client's Name (print) _____

Signature _____ Date _____

Psychotherapist's Name: Gloria Dahlquist, LMFT

Signature _____ Date _____

Minor Child's Name (print) _____Date_____

Mother/ Legal Guardian Name (print)_____

Signature _____Date_____

Father/ Legal Guardian Name (print)_____

Signature _____ Date_____

Psychotherapist's Name: Gloria Dahlquist LMFT

Signature_____Date_____