

Disclosure Statement & Agreement for Services

Fee for Service & Insurance Reimbursement:

Clients are expected to pay the standard fee of **\$100 per 45 min session** **\$125 for 60 min session** at the beginning of each session unless other arrangements have been made and **\$25 for each 15 min increment** at the end of the session if it goes over 60 minutes. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and otherwise agreed upon. **Services that are related to court proceedings such as writing reports, testifying in court phone calls to attorneys are billed at a higher rate of \$450 per hour and must be paid in advance.** Please notify the therapist (Ben Seigler) if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, the therapist (Ben Seigler) will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement if you so choose. Not all issues/problems/conditions, which are dealt with in psychotherapy, are reimbursed by all insurance policies. It is your (the client's) responsibility to verify whether therapy services are covered by your particular plan. If your (the client's) account becomes overdue (unpaid) and there is no written agreement on a payment plan the therapist may use legal or other means (courts, collection agencies, etc.) to collect payment.

I have reviewed, understand and agree to the stated policies regarding fees and payment_____

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The Process of Therapy/Evaluation and Scope of Practice:

Participation in therapy can result in a number of benefits to you and your family, including improving your relationships, self-esteem, manner in which you communicate as well as the resolution of the specific concerns that led you to seek therapy. It is your therapist's intention to provide services that will assist you in reaching your goals. Working toward these benefits, however, requires effort on your part. Therapy is effective most of the time. Clients who are motivated to change, willing to try interventions and strategies, honest about their issues and open with their therapist, are the quickest to see their desired results. The relationship with your therapist is crucial as well and has been identified as the single largest predictor for client's success. You should expect to see some results fairly early in treatment. If you aren't getting the benefit you would expect within the first few sessions this should be addressed at the beginning of the next session to determine the best approach to move forward. Your therapist will work with you as a partner, asking for your feedback and views on the therapy process, as well as providing feedback, in order to make adjustments to best meet your needs. Your therapist will also make suggestions, provide interventions and make recommendations based on his knowledge and training. You always have the right to disagree, ask for clarification or request a different strategy if you feel uncomfortable with what has been suggested. Due to the varying nature and severity of problems and the

individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

During the course of therapy your therapist will draw upon various psychological theoretical orientations. These may include: Family Systems, Experiential, Cognitive Behavioral, Gestalt, Solution Focused, Narrative, Existential, and others. Your therapist does not provide custody evaluation/recommendation, legal advice or medical advice (including advice regarding medications) as these services fall outside his scope of practice.

I have reviewed, understand and agree to the stated policies regarding scope of practice_____

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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 participate in 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 this therapist utilizes a “limited secrets” policy regarding information obtained between family sessions when conducting family therapy. This means that if you participate in family sessions, your therapist is permitted to use information obtained in an individual session that you had with him, when working with other members of your family. Please feel free to ask your therapist questions about his “limited secrets” policy and how it may apply to you.

I have reviewed, understand and agree to the stated policies regarding confidentiality_____

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Limits to Confidentiality:

There are limits to confidentiality. For example, all therapists are required to report instances of suspected child abuse, dependent adult abuse and elder abuse or neglect. Therapists may be required or permitted to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person or when a client is dangerous to him/herself.

Disclosure may 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 legal right to obtain the psychotherapy records and/or testimony by the therapist. In 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. The therapist will use his clinical judgment when revealing such information. The therapist will not release records to any outside party unless he is authorized to do so by all adult family members who were part of the treatment.

I have reviewed, understand and agree to the stated policies regarding limits to confidentiality_____

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Minors and Confidentiality:

Communications between therapists and clients 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 his professional judgment, may discuss the treatment

progress of a minor client with the parent or caretaker. Clients who are minors and their parents are urged to discuss any questions or concerns they have on this topic with their therapist.

I have reviewed, understand and agree to the stated policies regarding minors and confidentiality_____

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Cancellations/Missed Appointments:

I understand that my psychotherapist reserves a weekly appointment time for me. I agree to call 24 hours in advance if I must cancel a session in order to allow my therapist to reschedule his time. I understand that when I schedule an appointment, my therapist cannot have that space available for another patient. I realize that there will be a \$50 cancellation fee if I am not able to keep my appointment the first time I miss and that all subsequent missed appointments I will be charged the full price of the appointment. I also understand that after three missed appointments my therapist will likely refer me to another therapist since therapy is rarely effective when not attended regularly. If utilizing health insurance, I understand my insurance company will **not** reimburse for this expense and I will be responsible for paying the therapist at the normal contracted rate. I understand that if I miss two sessions in a row or three sessions total, my therapist will refer me to another therapist in the community and that I will receive my treatment elsewhere

I have reviewed, understand, and agree to the stated policies regarding cancellations_____

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Arbitration/Mediation Agreement:

I agree to address any grievances I may have directly with my therapist immediately. If we cannot settle the matter between us, then a jointly agreed-upon outside consultation will be sought. If not, an arbitration process will be initiated, which will be considered as a complete resolution and legally binding decision under state law. *By signing this contract, you are agreeing to have any issue of medical or psychological malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial.* It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly rendered, will be determined by submission to arbitration as provided by California law and in accordance with the rules of the American Arbitration Association, and not by lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and are instead are accepting the use of arbitration. Any arbitration process will be considered as a complete resolution and legally binding decision. The client will be responsible for the costs of this process. In agreeing to treatment, I am consenting to the above identified grievance procedures.

I have reviewed, understand, and agree to the stated policies regarding arbitration/mediation_____

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Emergencies:

If you need to contact me between sessions, please leave me a voicemail at (530)966-1242 and your call will be returned as soon as possible. I check my messages frequently during business hours, unless I'm out of town. I

Authorization to Bill Health Insurance/Assignment of Benefits

_____ (print name) do hereby give full authorization to Ben Seigler, MFT and his billing staff to bill _____ (name of insurance company) for services rendered by Ben Seigler, MFT including any services rendered by participating interns and/or other credentialed staffed therapists employed by Ben Seigler, MFT. I also agree to have any checks or payment made by said insurance company to be payable and deliverable to:

Ben Seigler, MFT
1178 Jewelflower Street
Plumas Lake, CA 95961

By signing this document, I also agree to the following statements below:

I understand that I am responsible for understanding information about my health insurance policy and providing such information to Ben Seigler, MFT for correct billing. I am also responsible to notify Ben Seigler, MFT in the case of change in my health insurance status and to make other financial arrangements with Ben Seigler, MFT in the event my health insurance benefits are terminated.

I understand that Ben Seigler, MFT will be providing services and billing my health insurance for those services at various times during the course of my care and may need to exchange information necessary to secure payment for these services. Such necessary information may include a diagnosis, service dates, types of services and other information related to processing claims.

I understand that ultimately I am responsible for all payment relating to any and all services that I have received through Ben Seigler, MFT and his staff. I also understand that my insurance company and related policy plan may offer benefits for services provided by Ben Seigler, MFT and his staff, but such benefits do not necessarily guarantee payment for these services. The undersigned does agree and understands all the statements made above.

X _____

Date: _____

X _____

Date: _____

Clients Signature/Parent or Guardian

Representative of Ben Seigler, MFT