Thom Kessler, LMFT, RAS
License CA 51868
1036 Sir Francis Drake Blvd.
Kentfield, CA 94904
415-454-8931

Welcome to my office. The following document is designed to give you information about my professional services and business policies. Please read this carefully. If you have any questions or concerns, please ask me at your first session, or as they arise during the course of treatment. Please note that when you sign this form, it represents an agreement between us.

AGREEMENT FOR SERVICE / INFORMED CONSENT

Introduction

This agreement is intended to provide_____
(Herein "Patient") information regarding the practices, policies and procedures of Thomas Kessler, LMFT (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Therapist has been practicing as a licensed marriage and family therapist (LMFT) and a registered addiction specialist (RAS) for 10 years, working mostly with adolescents and families.

Our first few sessions will involve an evaluation of your needs. Patient should address any concerns they have regarding process in therapy with Therapist. During this initial period, I want you to evaluate your comfort level with me as your therapist and address any questions you have about the process.

Risks and Benefits of Therapy

Psychotherapy as a process in which therapist and patient discuss a variety of issues, events, experiences and memories so patient can experience their life more fully. It provides an opportunity to better and more deeply understand oneself, as well as any problems or difficulties patient maybe experiencing. Psychotherapy is a joint effort between patient and therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy they result in a number of benefits to patient, Including, but not limited to, reduce stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increase comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence.

Participating in therapy may also involve some discomfort, including remembering and discussing feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which therapist will challenge patient's perceptions and assumptions and offer different perspectives. The issues presented by patients may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationships is the responsibility of the patient. There are no guarantees about what you will experience, or when or how fast you will feel improved.

Please initial hear that you have read and understand page 1: _____

Confidentiality

The information disclosed by patient generally confidential and will not be released to any third party without written authorization from patient, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence toward a reasonably identifiable victim, or when the patient is dangerous to him / herself or the person or property of another. In certain legal situations, such as a child custody case or when your emotional condition is an issue, the judge may order me to testify. In the event that an account with me goes unpaid it is legal for me to disclose your name, dates of session and amount due to a collection agency or small claims court as necessary.

Confidentiality with Family Therapy

When working with family members, I ask all parties to sign a release of information so that I may share relevant information and give important feedback to all those participating in treatment. In situations where one family member request that I release information about the another family member it is my policy not to release information unless all family members sign an authorization allowing me to do so.

Psychotherapist–Patient Privilege

The information disclosed by patients, as well as any records created, is subject to the psychotherapist – patient privilege. The psychotherapist– patient privilege results from the special relationship between therapist and patient in the eyes of the law. It is akin to the attorney– client privilege or the doctor– patient privilege. Typically, the patient is the holder of the psychotherapist – patient privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist – patient privilege on Patient's behalf until instructed, to do otherwise by Patient or Patient's representative. Patient should be aware that she/ he might be waving the psychotherapist– Patient privilege if she/he makes mental or emotional state an issue in a legal proceeding. Patient should address any concerns she/he might have regarding the psychotherapist – patient privilege with his/her attorney.

There are however exceptions to privilege, which includes, but is not limited to: 1) a patient is a danger to self or others, 2) a judge issues a court order, 3) a patient introduces his/her mental condition into testimony, 4) someone is under 16 and victim of a crime, 5) the court is using therapy to establish sanity or competence to stand trial, 6) a patient has treated information as though it is not confidential, 7) information pertaining to the Patriot Act, 8) information listed on the health insurance claim form or child abuse report, 9) a patient complaint or lawsuit against me.

Therapist Availability / Emergencies

You may leave a message at any time on my confidential voice mail 415-454-8931. Non-urgent calls are returned during normal workdays (Monday-Friday) within two business days. In the event of an emergency or an emergency involving a threat to your safety or safety of others, please call 911 or Marin Crisis Hotline 415-499-6666. Please do not email me except for scheduling.

Please initial here that you have read and understand and page 2: _____

Professional Consultation

Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Patient. For professional consultations (physicians, attorneys, School teachers, therapist, etc.), I charge in quarter hour segments for calls that are more than 15 minutes. I also charge for time writing letters/reports about your case or reading extensive reports. If you become involved in legal proceedings that may require my participation, you will be expected to pay for my professional time even if I am called to testify by another party.

Clinical records are maintained insecure confidential matter during treatment and for up to seven years following the termination of treatment. After seven years clinical records will be destroyed in a confidential manner and cannot be accessed.

Records and Record Keeping

Therapist may take notes during session. These notes constitute Therapist clinical and business records, which by law Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter the normal record-keeping process at the request of Patient. Should patient request a copy of Therapists records; such a request must be made in writing. Therapist reserves the right, under California law, to provide patients with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating healthcare provider. Therapist will maintain Patients records for seven years. However, after 7 years Patient's records will be destroyed in a manner that preserves Patients confidentiality.

Patient Rights

HIPAA provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. These rights include requesting that I amend you're a record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures unprotected health information that you neither consented to nor authorized, determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures in your records; and the right to a paper copy of this agreement, the attached notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Minors and Patients

Patients under 18 years of age who are not emancipated generally require parental consent in order to begin treatment. Parental consent must come from the parent or guardian with legal custody. If you're minor is the subject of a divorce union it is appropriate to bring a copy of your most recent custody agreement in order to initiate consent for treatment. In the case of a divorce, I prefer to have both parent's signature.

Please initial here that you have read and understand page 3: _____

Fees and Fee Arrangements

Fee for Individual Therapy service for a minor is *$200 for a 50-minute session*. Individual sessions longer then 50 minutes are charged for the additional time pro rata. Fee for family Therapy sessions is *$260 per 75-minute session.* Therapist reserves the right to periodically adjust this fee. Patient will be notified of any fee adjustment in advance.

From time to time, Therapist may engage in telephone contact with Patient for purposes other than scheduling sessions. Patient is responsible for agreed upon fee (on pro rata basis) for any telephone calls longer than 10 minutes. In addition, from time to time, therapist may engage in telephone contacts with third parties at Patient's request and with Patient's advance written authorization. Patient is responsible for payment of the agreed-upon fee (on pro rata basis) for any telephone calls longer than 10 minutes.

Patients are expected to pay for services at the time services rendered. Therapist accepts cash and checks. Credit cards - Visa and MasterCard will be considered.

If you would like an invoice to be sent to you at the end of the month, please discuss this with me. Please note there is a delayed payment charge after 30 days from the date issued on the invoice. The rate is a 5% charge based on the total of the invoice for every 30 days the invoice is unpaid.

Missed Sessions and Cancellation Policy

If you are late your appointment we still have to end on time for the courtesy of my next client and the fee remains the same because your fee is based on the amount of time reserved, not the amount used. I prefer not to see you if you are very sick, I will work to try to help you reschedule. If you have a set session time and you failed to show up or cancel in advance for three consecutive weeks, I will assume you're no longer interested in that time slot and make it available to other clients.

Patient is responsible for payment of the agreed-upon fee for any missed session. Patient is also responsible for payment of the agreed upon fee for any session for which Patient failed to give Therapist ***at least 24-hour*** *cancellation notice. Cancellation notice should be left on therapist's voice mail, email or text.*

Patient Litigation

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patients and another individual, are involved in any legal dispute. Therapist has a policy of not communicating with patient's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patients legal matter. Therapist will generally not provide records or testimony unless compelled to do so by a court order issued by a judge. If you become involved in legal proceedings that require my participation, you will be responsible for my professional time, including time for preparation if I'm called to testify by another party. My fee is $1800 for a half day (4-hours) and $3600 for a full day (8 hours) including travel time. My fees do not include the following expenses: any and all attorney fees, travel, accommodations and per-diem costs. Fees must be paid in advance.

Please initial here that you have read and understand page 4: _____

Termination of Therapy

Therapist reserves the right to terminate therapy at his discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interests, failure to participate in therapy, Patient's needs are outside the scope of competence or practice, or Patient is not making adequate process in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination policy and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to the Patient.

Acknowledgement

By signing below, Parent(s) acknowledges that they have reviewed and fully understand the terms and conditions of the Agreement. Parent(s) has discussed such terms and conditions with therapist, and has had any questions in regard to its terms and conditions of this Agreement and consents that their child participation in psychotherapy with Therapist. Moreover, Patient agrees to hold Therapist free and harmless from any claims, demands or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment

Parent Print Name:_____ DOB:_____

Signed:_____ Date:_____

Street Address:_____

City: _____ Zip code:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Work Street Address:_____

Work Phone:_____

City: _____ Zip code:_____

Email Address:_____

You may contact me via email or phone: _____

Emergency Contact:_____ _____

Please fill out below for your minor Child (under 18).

Child's Name: _____DOB: _____

School: _____Grade: _____

Email Address: _____ Cell phone: _____

Parent Print Name:_____DOB:_____

Signed:_____Date:_____

Street Address:_____

City: _____Zip code:_____

Home Phone:_____Cell Phone:_____

Email Address:_____

Work Street Address:_____

Work Phone:_____

City: _____Zip code:_____

Email Address:_____

You may contact me via email or phone: _____

Referred by:_____