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 FAMILY THERAPY / INFORMED CONSENT

Introduction

This agreement is intended to provide_____
(Herein "Patients") 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.

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 is a process in which the 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 may be currently 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 may 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 the 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 that your life has improved.

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

Confidentiality

The information disclosed by patient 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.

When working with family members, I may 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 family sessions, 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– patient 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 emails and 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 in a secure 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 the 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 your 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.

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

Fees and Fee Arrangements

Fee for family therapy is *$260 for a 75-minute session*. Sessions longer then 75 minutes are based on my hourly fee of $210 dollars. *Payment is made prior to the session, unless other payment arrangements have been made previously with the Therapist.* 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, checks, PayPal and credit cards - Visa and MasterCard.

If you would like an invoice to be sent to you at the end of the month, or third-party billing, 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 10% charge based on the total of the invoice for the first 30 days the invoice is unpaid. If payment has not been paid after 60 days from the date issued on the invoice the rate is 20%.

Missed Sessions and Cancellation Policy

If you are late to your appointment will still have to end on time for the courtesy of my next patient 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, and 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 patients.

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 48-hour*** *cancellation notice. Cancellation notice may be left on therapist's voice mail, or you can text or email therapist.*

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 I incur, travel, accommodations and per-diem costs. Fees must be paid in advance.

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

I have read and understand the information provided above. I have the right to discuss any and all of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

#1 Family Name:_____ DOB:_____

Signed:_____ Date:_____

Street Address:_____

City: _____ Zip code:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

You may contact me via email or phone: _____

#2 Family Name:_____ DOB:_____

Signed:_____ Date:_____

Street Address:_____

City: _____ Zip code:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

You may contact me via email or phone: _____

#3 Family Name: _____ **DOB:** _____

Signed: _____ Date: _____

Street Address: _____

City: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

You may contact me via email or phone: _____

#4 Family Name: _____ **DOB:** _____

Signed: _____ Date: _____

Street Address: _____

City: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

You may contact me via email or phone: _____

Referred by: _____