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CLIENT AGREEMENT FORM

I would like you to understand the policies, approach to treatment, and legal/ethical guidelines which make up part of the framework of the professional services I provide. Those services include psychotherapy, consultations, and reports. (For simplicity, the terms "services" and "psychotherapy" are used interchangeably in this form.)

If you can agree to the policies and legal/ethical guidelines contained in this form, then sign one copy, return it to me, and keep another copy. I reserve the right to revise these policies unilaterally from time to time.

SERVICES AND FEES:

Hours: A single "hour" of therapy is fifty minutes. If you are late, we will still end on time.

Missed appointments: Missed appointments with less than 48 hours–2 business days-notice will be charged a full fee, unless in my judgment there has been an emergency.

Fees: **Please indicate method of payment for therapy services:**

Payments are due in full at the time services are rendered. Payments will be made with Cash_____Check_____ ($35 returned check fee). I authorize Dr Levine to charge my credit/debit card for payments_____ (initial). A transaction fee of $2.50 for charges up to $99; $5.00 > $100-$500; $6.50 > $501 upwards. If your choice of payment is credit/debit cards, please note that I will keep your card on file in your confidential chart. Please update me on any changes to the card on file. Your authorization for this method of payment includes any charges being applied on the date of service for missed or late cancellations.

Print name on card_____

Visa _____ MasterCard _____ Discover _____ AmEx _____

_____
Credit Card Number Expiration Date 3 digit CVV code

_____ _____ _____

_____ _____
Billing Address City State Zip Phone Number

_____ _____
Signature Date

The fee for a fifty-minute "hour" is $_____ paid at the beginning of each appointment. In the unlikely event that you have not paid a fee within 60 days of the last date of services I reserve the right to send your account to a collection agency and to pursue payment through legal means if necessary. To keep up with the community standard of fees for my profession and expertise, I will at times increase my fees. I will notify you in advance of any increase.

Insurance: Please be aware that using insurance reimbursement involves an inherent breach of your confidentiality. I cannot prevent this information from becoming accessible to other individuals or insurance companies. This information may be used in the future by health, life or disability insurance companies to ascertain whether to issue you a policy, and what the premium might be.

- I do not have/or plan to use my health insurance_____
- Please bill insurance for me. I understand I am financially responsible for services denied by the insurance company, or if insurance coverage changes during my course of therapy_____

(If Dr Levine is a provider for your insurance company, she will undertake the direct submission of claims whilst she remains a provider). Please verify with her that she is currently a provider with your insurance company.

If you have insurance with a company that Dr Levine has no direct relationship with, and hope to utilize the reimbursement for an out-of-network provider benefit, it is your responsibility to collect reimbursement for the fee you pay to Dr Levine from your insurance company. Please request a statement for services which you can submit.

- I will bill my own insurance using the receipt provided_____

Telephone calls and emergencies: Due to the nature of this work, I do not answer my confidential office phone, (510) 524 1720 unless we have a prior arrangement. If it is urgent please leave a message on my office phone. I return all voicemails as soon as I am able. If I cannot reach you in good time, I urge you to immediately contact another professional or the emergency room of your local hospital. In Oakland/Berkeley the number for Alta Bates Hospital is (510) 204-4444. Because of my full schedule, I have a very limited capacity to respond to psychological crises and emergencies.

Changes in schedule: Please tell me in advance of any planned breaks in your regular schedule. I will also let you know of breaks in my schedule. Another therapist covers for me if I am out of town.

Termination of therapy: Good therapy ends. If I propose the ending, it is typically because you seem to have accomplished your therapeutic goals. Occasionally I feel that a client would be better served with a different professional. I also reserve the right to end therapy if a client does not adhere to these policies.

You may withdraw from therapy at any time. If you begin to feel that you need to or would like to end therapy, for whatever reason, please discuss this with me. Closure in psychotherapy is important, and usually calls for a few sessions prior to a mutually agreed-upon termination date.

Confidentiality: I respect your rights to privacy regarding information you share with me. I would like you to understand the legal and ethical limitations to confidentiality so that you can make an informed decision about what you disclose.

The typical way in which confidential information could be conveyed is if you specifically agree to disclosures of confidential material by me (such as allowing me to speak with your physician, former therapist, other family members, and so forth) as a means of furthering our work together.

Additionally, in atypical situations, I can be compelled or allowed under law or ethical

canons to disclose confidential information (and I am not required to inform clients of my actions) *if* any of the following conditions exist:
• My records are subpoenaed or my testimony is compelled, and I must comply with a legitimate court order.
• You are a danger to yourself or to the person or property of others, or unable to care for yourself. (Involuntary hospitalization may be required.)
• You make a serious threat of physical violence against a reasonably identifiable victim.
• I reasonably suspect that a minor is the victim of neglect or sexual, physical, or emotional abuse, or an elder or dependent adult is the victim of abuse.
• You seek my services in order to enable yourself or another to commit a crime, or to avoid detection of or apprehension for a previous crime.
• I am appointed by a court to assess you, to determine your sanity in a criminal proceeding, or to establish your competence under law.
• I must file a report which may become public (such as court-ordered psychotherapy within a drug-treatment program).
• After you have died, our communications are important to establish your actions or ntentions regarding your will or other disposition of property, or important to an issue between parties claiming through you.
• You have claimed mental/emotional damage as part of a legal action (such as after a car accident).
• You make or threaten a legal, administrative, or ethical claim against me.
• You default on a fee due me.

Risks of Psychotherapy: Therapy may be a valuable though elective personal growth experience, but not a medical necessity. The risks of therapy should be weighed against its benefits. Psychotherapy can be a difficult process with uncertain benefits. Despite our efforts, matters may be unpredictable. There is no promise of a "cure," or that you will solve the problem(s) or attain the goal(s) which brought you to therapy.

For you to get the most out of therapy, you will need to attend scheduled sessions. Spending some time each week contemplating the issues in therapy can be helpful.

If a couple comes to therapy, the couple may benefit in some ways while an individual member may not. In couples' counseling, my focus is on relationships and it is not my task to "fix" one family member or another.

By its nature, psychotherapy stirs things up. Sometimes feelings, desires, memories, surface to awareness or become more intense. This process of "stirring" may be welcome, but it can also be unsettling or distressing.

I have read, understood, and agree to the above:

Client name: _____

Client Signature _____ Date _____

Client name: _____

Client Signature _____ Date _____