INFORMED CONSENT & AGREEMENT FOR THERAPY SERVICES

Leslie Foge, MA, LMFT Psychotherapy Services

Bruce Sorenson, MA, Associate MFT (#120604)

Employed & Supervised by Leslie Foge (MFC#23841)
954 Risa Road Suite A
Lafayette, CA 94549
925 -323- 7126
brucesorensontherapy@gmail.com

Associate's Background:

Prior to entering the counseling field, I owned and operated businesses. As a younger man I received an MBA from JFK University and BA Economics from University of California, Berkeley. I graduated from Saint Mary's College of California with a master of arts in Counseling. In my studies I focused on marriage and family therapy and professional clinical counseling. Subsequent training was experienced at John F. Kennedy University (office of clinical training) where I worked with high school students, college students and young adults with the following concerns: grief & loss, trauma, depression, anxiety, OCD, ADHD and life transitions.

More information can be found on my website at www.brucesorensontherapy.com

Professional Consultation & Supervision:

As a registered associate, I will be receiving clinical supervision from Leslie Foge, LMFT #23841 and will consult with Leslie regarding my client's psychotherapy treatment in order to best serve my clients.

Professional consultation is an important component of a healthy psychotherapy practice and I may also consult with other professionals; client's names and other identifying information will never be mentioned.

Confidentiality:

All information between the client and associate therapist is legally protected and held in strict confidence unless the following situations occur:

1. The suspicion or evidence of child, dependent adult, or elder abuse and/or neglect exists (I am then required by law to follow the mandated reporting procedures).
2. The client presents a physical danger to self or others.
3. A court of law orders the release of information.
4. You have signed a release of information authorizing me to share confidential information.
5. If you are in couples or family therapy, information will not be disclosed about your treatment unless all parties provide written authorization to release. A "no secrets" policy will be intact if there is a reason to participate in an individual session while participating in couples or family therapy

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Therapy Process:

Therapy can be a difficult, as well as, rewarding process. When difficulties arise, it is important that you inform me so that they can be dealt with in an honest and direct manner. This includes but is not limited to, treatment issues, confidentiality concerns, appointment times and financial concerns. We are partners in the therapeutic process.

The length of your treatment and the timing of your eventual completion of therapy will depend on the specifics of your treatment plan and the progress that you achieve. We will work collaboratively to navigate the termination process.

Fees & Payments:

All fees for therapy will be collected at the time of service. $120 fee for 50 minutes and $165 fee for 80 minute sessions. Checks and venmo are accepted. *Please make checks out to Leslie Foge* and mail to 954 Risa Road Suite A, Lafayette, CA 94549. Venmo at: Leslie – Foge.

- Individual sessions are typically 50 minutes in length; couples and family sessions are typically 80 minutes in duration.
- Letter and report writing is billed at the same rate.
- Home visits and consultations, observations and travel time are also billed at the same rate.
- Calls over 10 minutes are considered therapy and are best handled during the scheduled sessions.
- If telephone consultation is needed, arrangements can be made so that an appropriate time is set aside. These calls will be billed at the same fee/time.
- Fees are increased by a modest amount, typically on an annual basis.
- Other fee arrangements should be noted here:

Reimbursement via Insurance:

Neither I, nor my supervisor, is a contracted provider with any insurance company or managed care organization. Should a client choose to be reimbursed through insurance, some insurance PPO's reimburse for out of network providers. If that is the case, the therapist associate will provide a "receipt of services" form to submit to your insurance at the end of each month for possible reimbursement.

- To be fully informed you should check with your insurance company at the beginning of treatment and inquire specifically about your mental health benefits and any limits that are placed on treatment (number of sessions, maximum amount reimbursed per session, whether reimbursement is offered for family sessions and whether reimbursement is granted when receiving therapy from a registered associate therapist.)

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Appointment Scheduling & 24 Hour Cancellation Policy:

Therapy sessions are usually scheduled to occur once per week and if possible scheduled during the same time and on the same day. Suggesting a different amount of therapy depending on the nature and severity of your concerns may be offered. Consistent attendance contributes to a successful outcome.

In order to cancel or reschedule an appointment, you must notify me at least 24 hours in advance of your appointment.

- You may leave a message 24 hours a day at 925-323-7126.
- With less than 24 hours notice, you will be charged for your missed appointment. In the case of someone other than the client assuming financial responsibility for treatment, the responsible party will be charged and notified of the missed appointment.
- There are no exceptions to the 24 hour cancellation policy. Thank you.

Contact Information and Emergency Procedures

If you need to contact me in-between sessions, you can leave a message on my confidential voicemail or text at 925-323-7126. Messages are reviewed once or twice daily. I will return your call as soon as possible. If you wish for me to return your call, please leave your name and phone number, along with a brief message concerning the nature of your call.

Email is limited to scheduling or practical concerns and noted that I cannot guarantee the confidentiality of this type of communication. Communication of a clinical matter should be addressed in person or by phone. I am not always available for an immediate emergency response.

In an urgent situation you can contact my supervisor, Leslie Foge at 510-332-2649.

****For life threatening situations, call 911, the Contra Costa Crisis Center at 800-833-2900, or go to your nearest emergency room. ****

Consent for Treatment of Minor (when applicable):

If any questions exist regarding the authority of Representative to give consent to psychotherapy, I will require the Representative submits supporting legal documentation, such as a custody order, prior to the commencement of services.

A minor patient will benefit most from psychotherapy when his/her parents; guardians or other caregivers are supportive of the therapeutic process. Communications between therapists and patients 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, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their registered associate therapist.

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Acknowledgements:

- The client has read & understands the information provided & agrees to the conditions presented.
- The client has had the opportunity to discuss all aspects of treatment fully.
- The client agrees to abide by the terms & conditions of the Agreement and consents to participate in psychotherapy.
- The client agrees to hold the therapist and supervisor 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.

FEES:

I am aware of the 24 hour cancellation policy and I agree to pay $120 (50 minutes) or $165 (80 minutes) to Bruce Sorenson in full at the beginning of each therapy session.

Print Name(s): _____

All Clients: (Please sign):

_____Date:_____

_____Date:_____

_____Date:_____

_____Date:_____

If the client is a minor (please sign below),

I hereby give consent for my child to receive psychotherapeutic treatment from Bruce Sorenson, MA, Registered Associate Marriage & Family Therapist #120604.

Parent Signature:

_____Date:_____

_____Date:_____