**TREATMENT AGREEMENT**

Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_ -- \_\_\_\_\_\_\_ -- \_\_\_\_\_\_\_

Phone (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: (Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist/Therapist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last examination date \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_.

Are you taking any medication or experiencing any health problems? Y/N (circle one)

If yes, please list:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose:\_\_\_\_\_\_Date first taken:\_\_\_\_\_\_\_\_\_Reason for taking: \_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose:\_\_\_\_\_\_Date first taken:\_\_\_\_\_\_\_\_\_Reason for taking: \_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose:\_\_\_\_\_\_Date first taken:\_\_\_\_\_\_\_\_\_Reason for taking: \_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose:\_\_\_\_\_\_Date first taken:\_\_\_\_\_\_\_\_\_Reason for taking: \_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose:\_\_\_\_\_\_Date first taken:\_\_\_\_\_\_\_\_\_Reason for taking: \_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose:\_\_\_\_\_\_Date first taken:\_\_\_\_\_\_\_\_\_Reason for taking: \_\_\_\_\_\_\_\_\_\_

Insurance Information Do you currently have insurance coverage? Y/N (circle one)

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan Type: PPO / HMO (circle one)

Your Name as it Appears on Your Insurance Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have Mental Health Coverage under this policy? Y/N (circle one)

*This document contains important information about the professional services and business practices of Burbank Therapeutic Centers, A Psychological Corporation. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.*

**Psychological Services**

We are a group of Licensed Psychologists and Psychological Assistants in the state of California, licensed by or registered with the California board of psychology. We are authorized under to perform psychological services within our scope of practice, including, but not limited to, individual, couples and group psychotherapy, psychological evaluation, diagnostic evaluations and psychological assessments.

**Assessment & Treatment**

Our initial sessions will involve an assessment of your needs. Typically, this evaluation will last from 2-4 sessions. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include. During this time, we can both decide if I am the best person to provide the services that you need in order to meet your treatment goals. Treatment can be time consuming and stressful. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

You are entitled to ask questions about all aspects of treatment. If you have questions about my procedures, we should discuss them whenever they arise. We will be happy to help you secure a consultation with another mental health professional whenever you request it or I recommend it.

**The Client’s Role**

You are expected to play an active role in your treatment, including working with me to outline treatment goals and completing questionnaires at the beginning of treatment and periodically during treatment to assess progress. You may be asked to complete homework assignments between sessions and your willingness to do this can be an integral part of a successful treatment. If at any point you are unhappy about the progress, process, or outcome of the treatment, please discuss this with me and we will attempt to resolve any difficulties that have arisen and to arrive at a treatment plan that better meets your needs.

**The Client’s Rights**

A document entitled “Patient’s Bill of Rights,” adapted from a publication by the California Department of Consumer Affairs, is attached. Please raise with me any questions that you might have.

**Meetings**

Therapy sessions are usually scheduled as 50 minute sessions once a week, or as your treatment needs dictate and we agree. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24-hous advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

**Professional Fees & Payment**

You will be informed of the fee for services no later than the end of the first appointment. You agree to provide payment for services, either in the form of a personal check (payable to Burbank Therapeutic Centers, Inc.) or cash, at the end of each session and to reimburse me for any and all bank fees for returned checks. Our hourly fee is $150. Longer sessions to be prorated based on this rate. Payment is due at the time of the session unless another arrangement has been made. Payment schedules for other professional services (eg: report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, and preparation of records or treatment summaries) will be agreed to when they are requested.

**Insurance Reimbursement**

If you have insurance and elect to seek reimbursement for your treatment, please let me know this by the end of the first session. Even if you do choose to use your insurance, it is the policy of Burbank Therapeutic Centers, Inc. that you pay for the full balance of the fees for services rendered up front. Any amount covered by the insurance company will be reimbursed directly to you. It is my responsibility to provide you with a “superbill” that the insurance company will use to determine appropriate reimbursement.

When you seek reimbursement most insurance companies require that I release any and all pertinent information regarding your treatment, including but not limited to, diagnosis, treatment plan, treatment progress, number of sessions attended, social security number (for identification purposes), and medications you have taken. In addition, you must be aware that once information is released to the insurance company, we cannot guarantee that it will remain confidential. Before we send any information to an insurance company, we will discuss with you the information to be disclosed and will obtain your written permission to release the information to your provider.

Some insurance companies require that the therapist be in contact with your primary care physician or psychiatrist. Therefore, it might be necessary to consent for those disclosures in order to obtain reimbursement and authorization for treatment from your insurance company.

Additionally, the signature on this form will authorize consent to bill your insurance company directly for services rendered. Each claim will display “signature on file” which will pertain to the signature on this document granting consent for treatment and to seek reimbursement.

**Confidentiality**

In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information about our work to others with your written authorization. However, there are a few exceptions:

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a patient’s treatment. For example, if we believe that a child, an elderly person, or a disabled person is being abused, we must file a report with the appropriate state agency.

If we believe that a patient is threatening serious bodily harm to another or are themselves at risk of physical harm due to a family member, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in our practice. If a similar situation occurs, we will make every effort to fully discuss it with you before taking any action.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. We will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

**Professional Records**

The laws and standards of my profession require that we keep treatment records. The Information in the chart includes demographic information, a description of your condition, your treatment goals, your treatment plan and progress in treatment, dates and fees for sessions and notes describing each therapy session.

Because these records contain information that can be misunderstood by someone who is not a mental health professional, it is my general policy that patients may not review them; however, we will provide at your request a treatment summary unless we believe that to do so would be emotionally damaging. If that is the case, we will be happy to send the summary to another mental health professional who is working with you. Patients will be charged an appropriate fee for any professional time spent in preparing and responding to information requests.

**Contacting Us**

You are welcome to contact Burbank Therapeutic Centers, A Psychological Corporation (818)208-1833 for urgent matters or clinical emergencies. You can also contact your individual therapist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. In the event of an emergency or imminent danger please call 911.

If your therapist is out of town or unavailable for any reason, we will provide coverage by a colleague and an announcement of such coverage will be made on the outgoing message of our voicemail system. We agree to take all reasonable precautions to ensure that all voicemail messages are returned within 24 hours and that all emergency pages are returned as soon as possible. Please note, however, that no telephone/voicemail system is 100% foolproof, and technical problems may occur. In the event an emergency page is not returned in a timely fashion, please call us again. In the unlikely event that you are experiencing a clinical emergency we have not responded, please call 911 for assistance.

**Acknowledgment**

Please do not sign if you have any questions regarding the contents of this letter or if any of the information is unclear. Thank you.

"By signing below, I acknowledge that I have read and understand the information presented in these six page of “Treatment Agreement” and that I give my consent for treatment to Burbank Therapeutic Centers, A Psychological Corporation.

This consent shall remain in effect for the duration of my therapy or until I provide written revocation of my consent to Burbank Therapeutic Centers, A Psychological Corporation. I further acknowledge that I have received a copy of this letter for my own records.”

Client's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Legal Guardian or Representative Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian or Representative Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Therapist’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_