***Emily Fleck, MFT***

22 West Micheltorena Street, Suite A (805) 618-1130

# Santa Barbara, CA 93101 Fleck\_Emily@yahoo.com



Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Sex: M F

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ e-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact & #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Person**: (Note: If this information is same as patient, write “same as above”)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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Phone: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Consent for Treatment:

I consent to assessment, treatment, and/or diagnostic procedures for myself or for my family member. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I authorize the release and exchange of information between my therapist and the referral source and other co-treating providers for the purpose of treatment, payment, and Health Care Operations. I also authorize the release of information to my health plan for claims or other health plan purposes.

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Patient/Legal Representative Signature Date



## Office Policies

### Confidentiality

All information disclosed within sessions or consultations is held strictly confidential and may not be revealed to anyone without a written release of information, except where disclosure is permitted or required by law. Disclosure is required in the following circumstances:

1. When there is a reasonable suspicion of child abuse or neglect, or abuse to a dependent or elder adult
2. When the patient presents an imminent danger to self
3. When the patient presents an imminent danger to others
4. If a judge determines that our discussions are not confidential, a judge may request specific information.

**If the patient is a minor, you acknowledge that your child’s records are confidential except in the above stated exceptions.** Please be aware that submitting mental health claims to your insurance company carries a certain amount of risk to confidentiality, privacy, and to future capacity to obtain health or life insurance, or even a job. I receive regular professional consultation and or supervision. In such cases, neither your name, nor any identifying information about you is revealed.

### Phone & Emergency Contact

If you need to contact me by phone, do not hesitate to call my office number at **805-618-1130**. If I am not available, you can leave a message on my voicemail and I will usually return the call that day. In the event of an emergency, you may be able to reach me on my personal cell phone at **805-451-8648**. You will be charged for phone calls if we have a conversation of an information-exchanging or problem-solving nature that lasts more than 10 minutes. If you cannot reach me in an emergency, you can find help at the following suicide prevention/crisis number: **(800) 824-6423**.

### Therapy Process & Termination

Psychotherapy can result in a number of benefits to you, including improved relationships and a reduction in psychological symptoms. The process of talking about painful memories, thoughts, and feelings, however, can be difficult and can make patients feel worse for a time. Please discuss this with me if you are feeling worse. There is no guarantee that therapy will yield positive or intended results. Most problems require at least 8-12 sessions. Many times it takes much longer than this, up to a few years. You are free to terminate therapy at any time. I can provide you with referrals to other therapists at your request. **I do not perform custody evaluations and do not make recommendations regarding custody.** I also do not prescribe medication or make recommendations about medication, but will refer you to your physician or to a psychiatrist if I believe you are in need of a medication evaluation.

### Cancellation of Appointment

The scheduling of an appointment involves the reservation of time specifically for you. In the event of a “No Show” or failure to give a **full 24-hour notice** of a cancellation, **you will be charged the full session fee for all late cancellations and missed appointments.** Please be aware that insurance companies will not cover cancellation charges. By initialing here, you acknowledge that you have received a copy of the “Notice of Privacy Practices” and the “Patients’ Rights and Responsibilities.” \_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient/Legal Representative Signature Date



**Fee Agreement**

**Fees:** I work on a sliding scale for couples/family therapy, and individual therapy. My fees are $120 to $80 depending on personal and financial circumstances. Sessions are 60 minutes in length. EMDR sessions are $150-$180 for a 90 minute session Letter writing, consultations with other professionals, telephone conversations, reading records or reports, travel time, longer sessions, etc. will be billed at the same rate as your therapy sessions. Returned checks are subject to a $20 fee. This agreement supersedes all previously agreed to financial agreements and is effective as of the date signed.

**Payment:** You can pay for your therapy with either check, cash, credit card, or Venmo. Payment is due at the end of your session. You can also pre-pay for your therapy sessions monthly should you choose to. It is your responsibility to remember to bring your checkbook to sessions. Clients are allowed to owe for two sessions. Upon the third session, if the client has not or cannot pay, I will not be able to see you until you are able to make a payment.

**Cancellation policy:** The scheduling of an appointment involves the reservation of time specifically for you. In the event of a “No Show” or failure to give a **full 24-hour notice** of a cancellation, **you will be charged the full session fee for all late cancellations and missed appointments.** Patients who fall ill or have a family emergency and did not provide a full 24-hour notice will be given leniency on the cancellation policy. If you continue to call in sick without adequate notice or, you have weekly emergencies, you will be charged the full fee for late cancellations and missed appointments.

I have read the above fee agreement document carefully, and I understand it and agree to all of its terms and conditions.

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Patient or Guardian Signature Date