OFFICE POLICIES & CONSENT FOR TREATMENT

James A. Powroznik, LMFT

Licensed Marriage and Family Therapist Lic #MFC 43539
5588 N. Palm Ave., Fresno, CA 93704 -1913
Cell # 559-916-0411
Email: jpmfc43539@att.net
www.jamespowroznik.com

Confidentiality: Information disclosed within sessions & the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law, or as otherwise provided & authorized by you as indicated at the end of this form, including disclosure required to process an insurance claim on your behalf,. **Disclosure is required by law** when there is reasonable suspicion of child, dependent or elder abuse/neglect or when a client presents a danger to self, others, or property, or is gravely disabled.

Litigation Limitation: Based on the nature of the therapeutic process and the disclosure of highly confidential information, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc...), neither you nor your attorney, nor anyone else acting on your behalf will call on James A. Powroznik to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. You may request your own proof of attendance, progress and prognosis for sharing with others as you see fit.

Your Right To Review Records: You have the right to review records or receive a **summary** at any time, except in limited legal or emergency circumstances or when it appears that releasing such information might be harmful in any way. In such a case records will be provided to an appropriate and legitimate mental health professional of your choice.

Payments, Insurance Reimbursement, Cancellation and Emergency Contact: Clients are expected to pay the standard fee of $100 for an initial intake, $80.00 per 50-minute follow-up individual session unless other arrangements have been made, including discounting on a case-by-case basis. Fees for professional, groups are individually arranged. Extended sessions, electronic consultations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, family and couple sessions, travel time, etc... are charged at the same hourly rate, in 15-minute increments, unless indicated and agreed otherwise. Clients who carry insurance are reminded that professional services are rendered and charged to the clients, not to the insurance company. Not all issues/conditions/problems which are the focus of psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If you need to contact James A. Powroznik between sessions, please leave a message on the number provided above between 6:00 a.m. to 9:00 p.m. for non-emergency calls; your call will be returned as soon as possible. A minimum 24-hour notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without notice. Most insurance companies do not reimburse for missed sessions. If an emergency situation arises, please indicate it clearly in your message. If you still need to talk to someone right away, call the local 24-hour crisis line, the Police (9-1-1), or 24 hour Emergency Psychiatric Services.

Dual Relationships: Therapy never involves sexual or business relationships or any other dual relationship which impairs the therapist's objectivity, clinical judgment, therapeutic effectiveness or which can be exploitative in nature.

(I)(We) agree to pay $_____ per (session)(month), at the time of service. Either party has the right to renegotiate this fee if circumstances change. (I)(We) agree to an initial series of ____ (appts)(months)(years)

(I)(We) have read the above Office Policy carefully, understand the Policy, agree to comply with the Policy, including the assignment of benefits if applicable and consent to engage in treatment.

(I)(We) authorize exchange of case information, including Diagnosis, Treatment Plan & Progress with

_____

_____
Client name (print) Signature Date

_____
Client name (print) Signature Date