

FONDA HART, LMFT
Licensed Marriage and Family Therapist
CA License # LMFT 39053
6042 N. Fresno Street, Suite 101, Fresno, CA 93710
559-801-1430

AGREEMENT FOR SERVICE / INFORMED CONSENT

Introduction

This Agreement is intended to provide you with important information regarding the practices, policies and procedures of Fonda Hart, LMFT (herein “Therapist”) and to clarify the terms of the therapeutic relationship between Therapist and Client. Any questions or concerns regarding this Agreement should be discussed with Therapist prior to signing it.

Confidentiality

Information disclosed by Client is generally confidential and will not be released to any third party without written authorization from Client, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, reporting child, elder, and dependent adult abuse; when a client makes a serious threat of violence toward a reasonably identifiable victim, or when a client is at risk of harming himself or herself.

When providing couples therapy, Fonda Hart has a “No Secrets” policy. This means that, if one partner in the couple-ship calls and shares something with the intent of withholding it from the other partner, Therapist will not hold this information as a secret but will work with that partner to bring the information into the couple therapy process. Secrets between one partner and Therapist undermine the effectiveness of the treatment process.

Fee and Insurance

Client is expected to provide full payment at time of session. Therapist has chosen to operate as an “out of network” therapist and is not a participating member of any insurance panels. A superbill will be provided so that Client may seek reimbursement from insurance.

If Client does not pay the balance in full, and Therapist has attempted unsuccessfully for 3 months to collect the balance owed, Client will be referred to a collections agency to recover the unpaid balance. When referral to Collections is made, adjustment or fee reductions will be reversed, and all sessions will be invoiced at full fee.

If during the course of therapy, Client requests that Therapist review a medical or legal report, or write a letter or treatment summary, Client agrees to reimburse Therapist for the time spent at the flat fee of \$150.

I understand that I am fully responsible to Therapist for all charges, including unpaid charges by insurance or any other third-party payor.

Initials: _____

24 Hour Cancellation Policy

In the event that Client needs to cancel a session, Therapist is to be notified at least 24 hours in advance. Client is responsible for payment of session fee for any missed sessions if 24-hour notice was not given.

I understand that I am responsible to pay for missed sessions and late-cancelled sessions.

Initials: _____

Therapist Availability

Therapist has a confidential voicemail that allows Client to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee calls will be returned immediately. Therapist is unavailable on weekends and holidays and is unable to provide 24-hour crisis service. In the event that Client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

Client may text Therapist at her phone number, but Client recognizes that confidentiality cannot be guaranteed.

Telemedicine

On occasion, Therapist may engage in telephone contact with Client for purposes other than scheduling sessions. Client is responsible for payment of the agreed upon fee for any telephone calls longer than ten minutes. A phone session longer than 15 minutes but less than 30 minutes will be billed at \$50. A phone session longer than 40 minutes but less than one hour will be billed at the normal session fee. Insurance companies do not generally reimburse for telephone sessions.

Some people prefer to schedule via E-mail rather than telephone. Although Therapist has an encrypted Email system, Client should be aware that E-mail is not as secure as telephone and Client assumes the risk for any violation of confidentiality that occurs in the E-mail communication. E-mail communication may be used for scheduling and other logistical needs, but not for therapy.

Initials: _____

Client Litigation

Therapist does not provide court reports, custody or court evaluations. Therapist does not provide testimony unless required to do so by law. If Therapist is subpoenaed, or ordered by court of law, to appear as a witness in an action involving Client, or as Expert Witness, Client agrees to reimburse Therapist for any time spent for preparation, travel, and any other time during which Therapist has made herself available for such an appearance at Therapist’s forensic rate of \$150.00 per hour.

Acknowledgement

By signing below, Client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Client has discussed any questions with Therapist and has his/her concerns addressed to Client’s satisfaction. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Client has a right to terminate therapy at any point. Therapist also maintains the right to terminate the treatment process if warranted. In that case, Therapist will offer names of other therapists who may be a good therapeutic fit for Client.

Client Name (*Please Print*)

Signature of Client (*or Authorized Representative*)

Date

Client Name (*Please Print*)

Signature of Client (*or Authorized Representative*)

Date

I understand that I am fully responsible to Therapist for all charges, including unpaid charges by insurance or any other third-party payor.

Name of Responsible Party (*Please Print*)

Signature of Responsible Party

Date