Susan Martinez
M.A., LMFT
Licensed Marital & Family Therapist

AGREEMENT FOR SERVICE/INFORMED CONSENT

Introduction

This agreement has been created for the purpose of outlining the terms of services to be provided by Susan Martinez, MA, LMFT and is intended to provide important information regarding the practices, policies, and procedures of Susan Martinez, MA, LMFT (herein "I" and "me") and to clarify the terms of the professional therapeutic relationship. Any questions or concerns regarding this agreement should be discussed with me prior to signing it. According to the ethics of the Marital and Family Therapy profession, everyone participating in the session is part of the treatment unit and is a client. Therefore, each person who will be in the session must read and sign this consent form.

Cancellation Policy If you must cancel a session, please do so by leaving a voicemail at 918.630.2201. A $20 fee will be charged for any missed session and also any session in which less than 24 hours notice was given.

Fee Arrangements

The usual and customary fee for service is $100 for a 45-50 minute session. Sessions longer than 50 minutes are charged for the additional time pro rata. I reserve the right to periodically adjust this fee. You will be notified for any fee adjustments in advance. In addition, this fee may be adjusted by contract with insurance companies or other third party payors or by agreement with me. Phone calls are billed at the same rate as face to face sessions.

The agreed upon fee is _____.

From time-to-time I may engage in telephone contact with third parties at your request and with advance written authorization. You are responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than 5 minutes. You are expected to pay for services at the time services are rendered. I accept cash (exact change), checks (please have them written out ahead of time), and credit card (via paypal). Receipts provided upon request, which you may be able to submit for reimbursement to your insurance or flexible spending account depending on your benefits. Check your plan for details. You are responsible for any and all fees not reimbursed by your insurance company, managed care organization, and any other third party payor. You are responsible for verifying and understanding the limits of your coverage, as well as your co-payments and deductibles. Not all issues/conditions/problems that are the focus of psychotherapy are reimbursed by insurance companies. For example, some insurance companies do not cover marital therapy. It is your responsibility to verify the specifics of your coverage.

Confidentiality

Therapy sessions are confidential. There are some legal and ethical exceptions to this confidentiality including; danger to self and others, and suspicion of child, elder, and dependent adult abuse. In couples and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. I will use clinical judgment when revealing such information. I will not release records to any outside party unless so authorized to do so by all family members (who are legally competent to do so) who were part of the treatment.

Email, cell phones, computers, and faxes: It is very important to be aware that computers and e-mail and cell phone communication can be accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, my e-mails are not encrypted, and faxes can be sent erroneously to the wrong address. My computer is equipped with a firewall, a virus protection and a password, and I also back up all confidential information from my computer to an external hard drive on a regular basis. Please notify me if you decide to avoid or limit, in any way, the use of any or all communication devices, such as e-mail, cell-phone or faxes. If you communicate confidential or highly private information via e-mail, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and I will honor your desire to communicate on such matters via e-mail. Please, be aware that e-mails are part of the medical records, and do not use e-mail for emergencies. Due to computer or network problems e-mails may not be deliverable, and I may not check my e-mails daily.

Permission to contact you via: email: ____yes_____no cell:_____yes_____no fax:_____yes____no

Consent for treatment of a minor child

I generally require the consent of both parents prior to providing any services to a minor.
The person who is legally able to consent for the child (e.g. legal guardian, custodial parent) is the person who must sign the consent form even if they are not participating in the therapy.

Risks and Benefits of Therapy

Psychotherapy is a process in which we will discuss a myriad of issues, events, and experiences for the purpose of creating positive change so that you can experience your life more fully. It provides an opportunity to better, and more deeply understand yourself, as well as any problems or difficulties you may be experiencing. Psychotherapy is a joint effort.. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Participating in therapy may result in a number of benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thought and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. Such benefits may also require substantial effort on your part, as well as caregivers and/or family members, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above. Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings, and experiences. This discomfort may also extend to other family members, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which I will challenge the perceptions and assumptions of you and other family members, and offer different perspectives. The issues presented by you may result in unintended outcomes, including changes in personal relationships. I do not make decisions about your life and your relationships for you. I will help explore and discuss issues and options, but you will make the decisions. For example, the decision to stay together or separate is made by the couple, not by me. During the therapeutic process, some clients find that they feel worse before they feel better. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. You should address any concerns you have regarding your progress in therapy with me. It is your decision if you wish to use insurance or pay out of pocket. Please be aware that using insurance carries some risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance.

Extra Therapeutic Relationships

I will avoid extra therapeutic relationships with clients. Not all extra therapeutic relationships are unethical or avoidable. I will assess carefully before entering into a nonsexual and nonexploitative extra therapeutic relationships with clients. It is a small community and many clients know each other and me from the community. Consequently, you may bump into someone you know in the waiting room, or we may have a mutual acquaintance. I will never acknowledge working therapeutically with anyone without his/her written permission. Many clients choose me as their therapist because they know me before they enter into therapy with me and/or are aware of my stance on a topic of concern. Nevertheless, I will discuss with you the often existing complexities, potential benefits, and difficulties that may be involved in such relationships. Extra therapeutic relationships can enhance therapeutic effectiveness but can also detract from it and often it is impossible to know that ahead of time. It is your responsibility to communicate to me if the extra therapeutic relationship becomes uncomfortable in any way. I will listen carefully and respond accordingly to your feedback. I will discontinue the extra therapeutic relationship if I find it interfering with the effectiveness of the therapeutic process or the welfare of you and of course you can do the same at any time. When extra-therapeutic relationships cannot be avoided, I shall take appropriate professional precautions to insure that judgment is not impaired and that no exploitation occurs. Examples of such extra therapeutic relationships include, but are not limited to, business or close personal relationships with clients. Therapy never involves sexual intimacy.

Termination of Therapy

If at any point during therapy, I asses that I am not effective in helping you reach the therapeutic goals, I am obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, I would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition. It at any time you want another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified, and, if I have your written consent, I will provider her or him with the

essential information needed. You have the right to terminate therapy at any time. If you choose to do so, I will offer to provide you with names of other qualified professionals whose services you might prefer.

Client Litigation

I will not voluntarily participate in any litigation, or custody dispute, in which you and another individual, or entity, are parties. I have a policy of not communicating with your attorney and will not generally write or sign letters, reports, declarations, or affidavits to be used in your legal matter. I will generally not provide records or testimony unless compelled to do so. I will not make any recommendation as to custody or visitation. I will make efforts to be uninvolved in any custody dispute. It is agreed that should there be legal proceedings neither you, nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Acknowledgement

By signing below, you acknowledges that you have reviewed and fully understands the terms and conditions of this agreement. You have discussed such terms and conditions with me, and have had any questions with regard to its terms and conditions answered to your satisfaction. You agree to abide by the terms and conditions of this Agreement and consent to participation in psychotherapy with me. Moreover, you agree to hold me 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. By signing below, you also authorize communication with the referring party for the purpose of assessment and treatment planning.

Adult Client Name (printed)	Date of Birth	Signature	Date Signed

Adult Client Name (printed)	Date of Birth	Signature	Date Signed

Minor Client Name (printed) Date of Birth Signature and Date Signed (if over age 14, otherwise parent/legal guardian signs and indicates relationship to minor)

Minor Client Name (printed) Date of Birth Signature and Date Signed (if over age 14, otherwise parent/legal guardian signs and indicates relationship to minor)

Minor Client Name (printed) Date of Birth Signature and Date Signed (if over age 14, otherwise parent/legal guardian signs and indicates relationship to minor)

Minor Client Name (printed) Date of Birth Signature and Date Signed (if over age 14, otherwise parent/legal guardian signs and indicates relationship to minor)

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

Name of Financially Responsible Person (printed)	Signature	Date Signed

Susan Martinez
M.A., LMFT
Licensed Marital & Family Therapist

INSURANCE INFORMATION

Please obtain the information about your mental health benefits from your human resources department or insurance company and complete the form below. Please note that your mental health coverage may be different than your medical coverage and may even be provided by a completely different insurance company.

PATIENT NAME:
ADDRESS:
PHONE: SS# DOB:
SEX:
EMPLOYER NAME/ADDRESS:
PATIENT OCCUPATION:
MARITAL STATUS:
Is patient's condition related to: employment? Y/N Auto accident? Y/N Or other accident? Y/N
Date of current illness/injury/pregnancy:
If patient has had similar or same illness, give first date:

PRIMARY INSURED NAME:
ADDRESS:
PHONE: SS# DOB
SEX
EMPLOYER NAME ADDRESS:
OCCUPATION:
MARITAL STATUS:

INSURANCE PLAN NAME OR PROGRAM NAME:
INSURANCE PHONE NUMBER:
ADDRESS TO SUBMIT CLAIMS TO:
INSURED ID #:
INSURED POLICY GROUP OR FECA NUMBER:
IS THERE ANOTHER HEALTH BENEFIT PLAN? If yes, provide additional information.
COPAY:
DEDUCTIBLE:
PRECERTIFICATION REQUIRED/RECEIVED? Y/N AUTHORIZATION NUMBER?

AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF BENEFITS

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to Susan Martinez, MA, LMFT.

Date Signature

I authorize payment of medical benefits to Susan Martinez, MA, LMFT.I hereby authorize Susan Martinez, MA, LMFT to apply benefits on my behalf for covered services rendered by Susan Martinez, MA, LMFT. I request that payment from my insurance company be made directly to Susan Martinez, MA, LMFT. I certify that the information I have reported with regard to my insurance coverage is correct.

Date Signature

2619 S. Elm Place Suite C1 Broken Arrow, OK 74012 Phone: 918.630.2201