Santa Maria Counseling
Greta Pankratz, MSW, LCSW
(LCS #25687)

1505 Shepard Dr., Suite 204, Santa Maria, CA 93454 **|**P.O. Box 434 Santa Maria, CA 93456 **|** (805) 268-5317

CLIENT CONSENT FOR TREATMENT

Please sign at the end stating you have fully read, understand and agree to the information below.

CLIENT/THERAPIST RELATIONSHIP: You and I have a professional relationship existing exclusively for therapeutic treatment. Our relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. I can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. We will discuss together how to approach possible social occasions where we might see each other, to avoid a breach of confidentiality. Gifts are not appropriate, nor is any sort of trade of service for service.

AVAILABLE SERVICES: Individual, couples and family therapy. Once I start individual therapy with a person, I cannot then start couples or family therapy as well. If we were to have an occasional couple or family session, those meetings would be centered around you, the individual, and how to help you meet your goals in individual therapy. If you should need additional types of therapy while in either mode of treatment, I will assist you with finding additional therapists as needed.

RISKS AND BENEFITS: Psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable or intense emotions such as anger, guilt, and sadness. Some patients re-experience physical pain (or develop new physical pain due to somatic experiences of stress), unwanted sexual arousal and defensive urges to fight, run or feel nauseous. Some types of therapy offered can cause suppressed memories to surface or change how you feel or think about memories. The benefits of counseling *often* far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, relief from traumatic symptoms and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy and offer you tools with which to deal with any uncomfortable feelings that may arise.

TRUST BETWEEN THERAPIST AND CLIENT: There are many reasons why telling the truth is ideal during your therapy. If at any time, you do not want to answer a question, it is important you are honest about that. You can simply say, "I'd rather not talk about that right now". If you are not sure what you are feeling or thinking, you can be honest about that. If at any time you decide to end treatment because of any reason, it is ideal to say that so I can help with a referral and make the transfer easy. There will be times I will make assessments; I encourage you to ask questions or raise concerns if you have them or don't agree.

COUNSELING: I provide short-term or long-term counseling designed to address many of the issues that clients are dealing with. Your first visit will be an assessment session in which you and I will discuss your concerns, determine your goals and if you decide that I can meet your therapeutic needs, I will develop a Treatment Plan with you. If we find we are not a match at any time during treatment, I will help refer you to a therapist you and/or I feel is better suited to meet your needs.

NO-SECRETS POLICY (Couples): I have what is known as a "no secrets" policy in couples counseling. This means if I ever work with either of you on a 1:1 basis, and I learn information about the relationship (such as an affair, illness, addiction, etc.) and your partner does not know, I will work with you to help you disclose that secret to your partner. However, if you refuse to disclose that information and my keeping the information only puts me in the middle of your marriage or partnership and harms the therapy, I hold the right to make that disclosure or terminate treatment.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are **50 minutes long**. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by you and I. **If you must cancel or reschedule your appointment, I ask that you call my office at least 24 hours in advance to avoid being charged $50.** This will free your appointment time for another client.

FEE SCHEDULE:

Initial Screening phone call (10 minutes)	FREE
Initial Diagnostic Assessment Session	$125.00
Regular Therapy Session (50 minutes) (Individuals & Couples)	$ 100.00
Family Sessions (90 minutes)	$ 150.00
Outside Office Work (In-patient/Hospital visits, School meetings)	$ 100.00/hr
Returned check fee per check	$ 25.00
No-Show fee (for failure to cancel 24 hrs prior to appointment)	$ 50.00
Clinical Supervision (on site)	$ 75.00/hr
Paperwork fee (letters, reports, emails to collaborate care)	$ 20/15 min.
Training	$ 200/hr
Crisis Debriefing	$ 120/hr
Groups	Fee negotiable

A reasonable fee will be charged for copies of any records requested by the Client.

Please ask to discuss my sliding scale should these fees be too high given your current financial state.

PAYMENT/INSURANCE FILING:
-Payment of fees, including any required co-pays, is due by the end of each appointment.
-If I am a preferred provider for your insurance policy, I may offer to bill your insurance for you as a courtesy. If your insurance denies payment or becomes too laborious to bill, you will be provided the necessary information to be able to bill your insurance on your own. In that event, you will be required to pay Santa Maria Counseling directly and then seek reimbursement *on your own*, from your own insurance provider.
-All other services will be Fee for Service. Cost will be agreed upon prior to services commencing.
-If I am not a Provider of your Insurance Carrier, we can discuss payment options as an Out-Of-Network Provider. These arrangements will be discussed and agreed upon during your first session or have already been discussed when we spoke on the phone.
-If you wish to file your own claim, I expect full payment at the time of service, and I will provide you with a receipt for services rendered.

I agree with the hourly rate and understand that ultimately, I am responsible to ensure payment is made for services. I understand that my insurance is billed for me as a courtesy, and that ultimately it is my responsibility to discuss and understand payment/coverage of services with my insurance prior to treatment. I understand I am responsible for any additional service fees (including No-Show fee of $50).

Initial: _____

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact my office via phone or email (I receive email more often and more quickly) regarding the nature and urgency of the circumstances. Since I work limited hours and limited days, I may not be able to return your call for up to a week. My limited schedule aside, I will make every effort to respond to your emergency in a timely manner.
Please leave a message about your emergency and then complete the following.

- In a life-threatening emergency (including suicidal thoughts), call 9-1-1 or go to the nearest emergency room.
- During a non-life-threatening crisis, call the 24/7 Access/CARES team at 1-888-868-1649 for a live person to talk with. In a non-life-threatening crisis, you may also call 2-1-1 or 1-800-400-1572 for 24/7 access to a person to talk with.
- If the non-life-threatening crisis involves a child (or person under age 21), please call SAFETY at 1-888-334-2777 for 24/7 access to a live person.

When your Therapist is sick or on vacation, you will be given advanced notice and should contact 911 or go to the nearest Emergency Room for immediate assistance. **Initial: _____**

CONFIDENTIALITY: I, Greta Pankratz, LCSW (LCS #25687) make every effort to follow all legal and ethical

standards prescribed by state and federal law. Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law.

By Law, the following are the exceptions to Confidentiality:
Suspected Child Abuse: The therapist is required by law to report this to the appropriate authorities immediately.
Suspected Abuse of Dependent or Elderly Adult: The therapist is required by law to report to the appropriate authorities immediately.
Intent to harm self: The therapist is required by law to report to the appropriate authorities for further evaluation. The therapist will make every effort to enlist their cooperation in insuring their safety. If they do not cooperate, further measures may be taken without their permission in order to ensure their safety.
-Intent to harm others: The therapist is required by law to report to the authorities and intended victims for further investigation.
Additional exceptions to confidentiality include but are not limited to the following situations: abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. I will make every effort to discuss my obligation to break confidentiality with you prior to doing so, should one of the above situations arise. *If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further.* By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from confidentiality.

Initial: _____

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to Greta Pankratz, LCSW (LCS# 25687) to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name	Relationship to Client	Telephone Number
_____	_____	_____

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, talked about with my therapist and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me, and I understand that I may stop such treatment or services at any time.

_____ _____
Signature – Client Date