

Mariefrance Cote, LMFT

Therapy for the Whole Family

California License #52000

415.997.0020

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www.TherapyForTheWholeFamily.com

Client Informed Consent

1. Psychotherapy

I understand that I, or my child, will meet with Mariefrance for 50-minute sessions on a weekly basis unless other arrangements are made. _____

Additionally, I understand that termination of therapy will be discussed in advance in order to allow time to summarize the work we have done together and to complete the therapeutic process. _____

It is my intention to provide services that will assist you in reaching your goals and achieve greater well-being. Based upon the information that you provide and the specifics of your, or your child's situation, I will provide recommendations to you regarding treatment. I believe that therapists and clients are partners in the therapeutic process. Remember, therapy is a service that you purchase, and if you are not happy with the services received, it is your responsibility to make that known so we can discuss any hindrances to your progress. However, there is no guarantee that therapy will yield positive or intended results. Because feelings will be explored, you may feel a range of emotions that can be intense and uncomfortable at times. During the course of therapy, some of your assumptions, perceptions, or behaviors may be challenged, which can cause you to feel upset, angry, depressed, uncomfortable, confused, or disappointed. I encourage you to explore those feelings during our sessions, as they are part of the therapeutic process.

I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion. During the course of therapy, if I assess that I am either unable or not effective in helping you reach your therapeutic goals, I will discuss this with you, and if appropriate, terminate treatment. I will provide you with appropriate referrals and assist you in the transition to a new therapist if you so desire.

Therapy is a unique and highly individual experience with the outcome determined by the effort and motivation you bring to work towards a change in yourself and how you see the world around you.

Due to the varying nature and severity of problems and the individuality of each client, I am unable to predict the length of your therapy or guarantee a specific outcome or result.

2. Fees

Session fee is \$225 for an Intake session for 80min, and \$150 per 50-minute session. The fee is due at each session unless otherwise agreed upon and is payable by cash, check, or credit card.

Due to charged fees with credit card payments, an additional \$3 will be added to the session fee ____

I understand that my fee will be reviewed annually and that I may be billed for any additional consultations or phone sessions. ____

I am responsible for any unpaid balance. If I do not pay my bill, my therapist may turn my bill over to a collection agency. ____

Phone Consultations or emails: If my work with you or your child involves phone consultation or email consultation with you, teachers, lawyers, doctors, or other providers, you will be billed for this time at my hourly rate. There is a minimum fee of \$35 for this service.

Written Reports: I will bill you in 15-minute increments for time spent reading reports. If you request written reports, letters, etc. you will be billed for this time in 15-minute increments based on the full fee. There is a minimum 30-minute charge for this service.

Legal Proceedings: If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge double my hourly fee for preparation and attendance at any legal proceeding.

School Visits: A school consultation is billed at my hourly fee with an additional hour at full fee for traveling time. After the consultation, you will receive a comprehensive list of recommendations for your child.

3. Cancellations

Your commitment to therapy is fundamental to your progress. Cancellations are reserved for serious events. If you must cancel an appointment due to illness, a family emergency, or other serious event, Mariefrance Cote needs least **48 hours** notice or you will be billed for missed session. ____

If you must cancel your session without a 48 hour notice, I will do my best to offer you other times for rescheduling for the same week. If your regular session time is rescheduled for the same week, then you will only be expected to pay for the appointment you attend.

4. Confidentiality

All information exchanged between Mariefrance Cote and I is held strictly confidential unless (a) I authorize the release of the information, (b) Mariefrance Cote is ordered by a court to release information, (c) I pose a serious danger to myself (suicide), (d) I threaten to physically harm others, or (e) child abuse or dependent adult abuse is suspected. In the latter two cases (d and e), I understand that Mariefrance Cote is required by law to inform potential victims and legal authorities so that protective measures can be taken ____

5. Communication

I will use 415-997-0020 for messages. Mariefrance Cote will return my call the same day or as soon as possible. ____

I understand that e-mails are vulnerable to unauthorized access and are part of the medical records. I will notify Mariefrance Cote if I decide to avoid or limit the use of e-mail, cell-phone, or faxes. ____

If I am having a psychological emergency and Mariefrance Cote is not available, I will use crisis services: Suicide Prevention: 415-781-0500 and S.F. General Hospital Psychiatric Emergency 415-206-8125 (24 hour). ____

6. Consent to treat a minor

I, _____ give permission to/authorize Mariefrance Cote,

MFC #52000 to assess, diagnose, and treat my child in psychotherapy. This authorization will expire one year from the date below _____

I understand that confidentiality is an essential part of the relationship my child has with her therapist. I agree to respect that relationship and the limits of it. If I have questions or concerns about my child or his/her participation in therapy, I agree to contact the therapist myself and request a joint session with my child. _____

Should I decide to terminate treatment for my child for any reason, I agree to notify the therapist in advance and, if it is appropriate, allow my child an additional session(s) to discuss the progress that was made thus far, the significance of the relationship and its ending. _____

E-Mails, Cell Phones, Computers, and Faxes

* It is very important to be aware that computers, e-mail, and cell phone communication can be relatively easy to access by unauthorized people and e-mails, in particular, are vulnerable.

Mariefrance Cote e-mails are not encrypted* Mariefrance Cote's computers are equipped with a firewall, a virus protection, and a password, and she also backs up all confidential information from her computers on to a USB device on a regular basis. The USB device is stored securely in a locked file cabinet.

* If you communicate confidential or highly private information via e-mail, Mariefrance Cote 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 she will honor your desire to communicate on such matters via e-mail. _____

Please initial each line, print name/date, and sign.

I have read the foregoing and I understand the policies stated herein and agree to the stated conditions.

Name _____

Address _____

Signature _____ Date _____