Marnee Reiley, M.A., LMFT
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NEW CLIENT INFORMATION

Welcome to the practice. I look forward to our work together. This document contains important information about my professional services and business policies. Please read it carefully and make note of any questions that you might have so that we can discuss them during our session. Please sign your initials on the lines provided following each section, indicating that you have read and agreed to my policies. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general terms. It varies depending on the personalities of the therapist and client, and the particular difficulties with which you are struggling. There are many different methods I may use to deal with the problems you hope to address. Psychotherapy is not like a visit to a medical doctor. Instead, it calls for a very active and consistent effort on your part, in sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing challenging aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. There are no guarantees of what you will experience. Sometimes psychological services are provided primarily to prevent further deterioration of your mental or emotional status which is considered maintenance treatment.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money and energy, so you should be very careful about the therapist you select. If you have any questions about my procedures, we should discuss them whenever they arise. If your doubt persists, I will be happy to refer you to another mental health professional for a second opinion.

_____ (Please initial)

APPOINTMENTS AND CANCELLATIONS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time I will be gathering information regarding your background, presenting difficulties, and current

mental health symptoms in order to formulate a clinical diagnosis. If you decide to continue treatment, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree upon. *Once an appointment hour is scheduled, you will be for payment of the fee unless you provide 24 hours advance notice of cancellation.*

_____ (Please initial)

PROFESSIONAL FEES

My standard session fee is $140. In addition to weekly appointments, I charge this amount for other professional services that you may need, though I will break down this hourly cost if I work for periods of less than one hour. Other services include: report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you request of me. 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 $500 per hour for preparation and attendance at any legal proceeding.

_____ (Please initial)

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. If you wish to pay by check, please make it payable to: Marnee Reiley. To avoid wasting your valuable session time, please have your check made out and ready before your session. In circumstances of unusual financial hardship, I may be willing to negotiate a temporary fee adjustment.

You are responsible for ensuring that your account balance is paid in full. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, such costs will be included in the claim. In most collection situations, the only information I will release regarding a client's treatment is the client's name, the nature of services provided, and the amount due.

_____ (Please initial)

INSURANCE BENEFITS

It is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. You should carefully read the section in your insurance coverage

booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. In order for you to receive your insurance benefits, some insurance companies may require you to authorize the provider to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. At times, they may share information with a national medical information databank. I will provide you with a copy of reports I submit, if you request it. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services via private pay to avoid the problems described above.

_____ (Please initial)

CONTACTING ME

I am often not immediately available by telephone. You may leave a confidential voice message that I monitor periodically throughout the day. I will make every effort to return your call within one business day, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. Telephone calls are offered as a professional courtesy and this service does not constitute an emergency psychological service. I am not responsible for your behaviors or decisions occurring outside the consultation room at any given time, whether before or after a telephone call or consultation. If you are unable to reach me and feel that you can't wait for me to return your call, contact 911, your family physician or the nearest emergency room and ask for the psychologist (psychiatrist) on call. If I am unavailable for an extended period of time, a qualified professional will be available for you to contact during my absence.

_____ (Please initial)

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy or summary of your records. These professional records can be misinterpreted by untrained readers. Therefore, if you wish to view your records, I recommend that you review them in my presence so that we can discuss the contents.

_____ (Please initial)

MINORS

If you are under eighteen years of age, please be aware that the laws may provide your

parents the right to examine your treatment records. It is my policy to request a verbal agreement from your parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

_____ (Please initial, if applicable)

CONFIDENTIALITY

In general, the privacy of all communication between a client and therapist, including that of minors, is protected by the law. Therefore, I am not at liberty to release information to another professional or interested party without written permission, except where disclosure is permitted or required by law. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. Disclosures may be required in the following circumstances:

(1) When there is a reasonable suspicion of child abuse. elder abuse, or abuse of a dependent adult. In this case I am required by law to file a report with the appropriate state agency.
(2) If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.
(3) If the client threatens serious bodily harm to himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
(4) When disclosure is required pursuant to a legal proceeding. (i.e., court order)
(5) In the event that the services of an attorney and/or collection agency is required to pursue any past due fees.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During consultation, neither your name nor identifying information about you will be revealed. The consultant also is legally bound to keep the information confidential.

_____ (Please initial)

TERMINATION

Your participation in psychotherapy and other psychological services is voluntary and you have the right to withdraw from treatment without adversity at any time. I would recommend that when termination is considered, you discuss this with me, so we can

create a plan for termination to minimize any possible negative effects. If you don't show-up for 3 consecutive scheduled appointments, your treatment will be considered terminated and you will be financially responsible for the fees of the missed sessions. A letter will be sent to you acknowledging the termination along with a closing bill for any unpaid balance.

_____ (Please initial)

CONSENT FOR TREATMENT

I, _____, authorize and request that Marnee Reiley, M.A., Licensed Marriage and Family Therapist, CA lic. # 83021, provide treatment, and/or diagnostic procedures which are advisable during the course of my care as a client.

I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and that, at times, I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

I understand that my participation in psychotherapy is completely voluntary and that I may terminate psychotherapy at any time.

I have received a copy of the New Client Information packet. I understand that the purpose of these guidelines is to clarify the nature of our professional relationship.

My signature below indicates that I have read and fully understand the information provided in the New Client Information packet and I agree to abide by its terms during our professional relationship.

_____ _____
Client's Signature Date

_____ _____
Parent/Guardian's Signature Date

_____ _____
Marnee Reiley, M.A. Date
Licensed Marriage and Family Therapist (CA lic. 83021)

Revisions to above agreement, if any, are as follows:

The fee for the four-week series of the Adult Children of Aging Parents group is $120 payable at the first session. As a four week commitment is requested to reserve a spot in the group, and to encourage group cohesion, no refunds will be given for missed sessions.

_____ _____

Marnee Reiley, M.A. Date

_____ _____

Client Signature or Guardian if Client is a Minor Date

ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information and return this form to your provider. Session fees for all clinical treatment will be deducted from the account designated on this form and will be noted as a ***"SQ Marnee Reiley, M.A., LMFT"*** transaction on your bank statement. Forms of payment accepted: Visa, MasterCard, Discover, American Express, check and cash. This form will be securely stored in your clinical file and may be updated upon request at any time.

***CLIENT INFORMATION*:**

Client Name:_____ DOB:_____

Responsible Billing Party Name (as shown on Credit Card/Account)**:_____**

Billing Address (as registered with Credit Card Company/Bank)**:**

_____

Mobile Number:_____ Home Phone Number:_____

Email_____

***FORM OF PAYMENT*:**

Check One: Credit/Debit Card: **_____** Cash _____ Check: _____

***ACCOUNT INFORMATION*:**

Card Type (Visa, MasterCard, or Discover):_____

Card#:_____

Expiration Date:_____

Three Digit Card Code (Located on Back of Card): _____

Client Signature_____Date_____

Special Instructions: