

## Client - Therapist Agreement

This agreement was prepared for new clients to answer some of your questions about the professional services offered by Scherry Messic, Ph.D., and to help clarify important practice policies. This agreement, combined with a practice brochure, is intended to help you make informed choices concerning your treatment. Please read it carefully and write down any questions you may have so that we can discuss them. When you sign this document, it represents an agreement between us.

**SESSIONS:** Sessions are for 50 minutes. Longer or shorter sessions can be made with prearrangement, and are prorated from your basic fee for 50 minutes.

**Cancellations:** Your appointment time has been reserved exclusively for you in order to best serve you. If you are unable to keep an appointment, please notify me as soon as possible, with a minimum of one business day notice. ***If an appointment is cancelled or missed without 24 hours prior notice (business days), you will be charged for the session.*** Insurance companies do not cover missed appointments. I will also give you advanced notice (normally 30 days) if I am planning on being away from the office.

**REMINDER CALLS:** Courtesy calls to remind you of your appointment from support staff are a routine part of my practice. Please provide a phone number appropriate for this purpose, or let me know if you do not wish to receive appointment reminder calls.

**PHONE CALLS:** I am often not immediately available by telephone. While I am usually in my office Monday through Thursday, 9 AM to 5 PM, I do not answer the phone when I am with clients. When I am not available, my telephone is answered by voice mail. If you need to leave me a message, or you would like a return phone call, please call (619) 993-3227. In non-emergency circumstances I will generally get back to you the next business day. If you are in a crisis, and need to talk with me immediately, I can be paged at (619) 506-3227, and will respond within approximately four hours in most circumstances. In an emergency, go to the nearest emergency room, or call the crisis/access line: 800-479-3339.

**CONFIDENTIALITY:** Confidentiality is a vital part of the therapeutic process. Professional ethics and California law specifies that confidentiality extends to all areas of the therapist/client relationship, from the content of your session to the fact that you are being seen, and cannot be released or shared without the express permission of the client. This confidentiality applies to everyone, including family members. There are, however, some special circumstances under which confidentiality can (and sometimes must) be overruled by your therapist. Those circumstances are: 1) If you give prior written permission by signing a release form; 2) If I am subpoenaed, and the court waives the therapist-client privilege; 3) If I know or suspect child abuse or neglect. Mandatory reporting laws concerning suspected child abuse or neglect supersedes confidentiality. I must legally report all knowledge of child abuse and/or neglect. Laws concerning what constitutes child abuse and neglect, and therefore what must be reported, are fairly specific.; 4) If I know or suspect elder or dependent adult abuse or

neglect, as it is defined by the law; 5) If you express the intent of bringing harm to yourself or another person(s), or if a family member communicates to me that you have communicated a danger to others. In such circumstances, I am required to inform potential victim(s) and legal authorities. If any of these situations occur, I will make every effort to discuss it with you before taking any action.

When I am away from the office, I have a trusted fellow therapist “cover” for me. This therapist will be available to you in emergencies. To provide this coverage, he or she will need to know about you. This therapist is also bound by the same laws and rules as I am to protect your confidentiality. As part of maintaining your privacy, if we meet on the street or socially, I will not discuss professional concerns or indicate that you are a client.

**TREATMENT APPROACH:** My background, education, experience, approach, and specialties are outlined in my brochure and web site ([www.drscher.com](http://www.drscher.com)) .

The nature, length, and likely results of the treatment provided to you will be based on your unique needs and goals. Some issues can be effectively addressed in one to six sessions, generally using a brief therapy approach. Some issues require longer. We will discuss the approach to be used, alternative approaches, any risks involved, and an estimate of the length of therapy. I view therapy as a partnership between us. To practice new skills that you learn in our sessions, we may work together to set up tasks, reading or exercises for you between sessions. There are no instant, painless cures, and no “magic pills.” For enduring change to occur, most clients will engage in a significant degree of self-examination and begin to take incremental steps toward meeting their goals, typically feeling worse as they institute lifestyle change before they feel better. However, you can learn new ways of looking at your problems that will be very helpful for changing your feelings and reactions.

The first one to three sessions, I will be asking you a lot of questions in order to complete an initial evaluation of your needs. This time also gives us both an opportunity to decide if I am the best person to provide the services you need in order to meet your treatment goal. If you have questions about the processes and procedures we are using, please bring them to us so we can discuss them.

In keeping with generally accepted standards of practice, I frequently consult with other mental health professionals regarding the therapy I provide. The purpose of this consultation is to ensure optimal clinical care. Every effort is made to protect the identity of clients when consulting with other professionals.

In keeping with the standards of the practice of psychology, there are rules and limits to our relationship which I will follow. I can only be your therapist. I cannot have any other role in your life at any point, such as close friend or business relationship, including socializing.

I follow the standards of the American Psychological Association, and all laws and regulations of the California Board of Psychology. If you are not satisfied with any area of our work, please raise your concerns with me at once. Our work together will be much more productive if your concerns are addressed. If you feel I, or any other therapist, has treated you unfairly or has broken a professional rule, please tell me. Should you have questions, or wish to file a complaint you can contact the California Board of Psychology, which is the organization that licenses those of us in the

independent practice of psychology, at (916) 263-2699; 1422 Howe Ave., #22, Sacramento CA 95825.

**FEES:** Payment for services at the time of service is the client's responsibility (or parent/guardian, if the client is a minor). My usual and customary fee for an initial evaluation is \$200, and \$150 per 50 -minute clinical hour for an individual, couples, or family. I charge this amount for other professional services you may need, and I will break down the hourly cost if I work for periods of less than 50 minutes. Other services include report writing, telephone conversations lasting longer than ten minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and time spent performing any other service you may 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, my fee is \$200 per 50 minutes for preparation and attendance at any legal proceeding. Payment is due at the end of each session, unless you have made prior arrangements with your therapist. Payment schedules for other professional services will be agreed to when they are requested. Should you break the financial arrangements as detailed above, please understand that your name may be released for collection purposes. If you have any questions concerning your fee please ask.

**Insurance And Third Party Payments:** If you wish to file a claim for services with your insurance carrier, please let me know. I am happy to assist you with that process so that you can get reimbursement. With prior arrangements as a service, I will bill your insurance directly for the services provided. I cannot guarantee benefits or the amount covered. The entire fee is the responsibility of the client, regardless of the insurance company's determination of payment. You should also be aware that most insurance companies require you to authorize me to provide them with your clinical diagnosis, and sometimes additional clinical information such as treatment plans. This information becomes part of the insurance company's records, which they keep confidential.

**RECORDS:** The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records if you wish unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. You will be charged my standard fee (prorated basis) for this, or for any time I spend in preparing information requests.

**COUPLES:** If you and your partner decide you wish to receive couples or marital counseling, it is important that you understand in such cases you are both my clients. My agreement is with the two of you. As such, I do not see one member of the couple alone without a prior arrangement and mutual understanding. Any information shared in an individual session would need to be brought back into sessions with the two of you. Further, in the event that you wish me to share information about your treatment with another professional or person, both parties must agree to and sign a release of

information before any information can be shared. If one of you does not wish the information shared, then it cannot be released. Finally, you both must agree at the start of treatment that if you decide to divorce, you will not request my testimony for either side.

**CLIENT SATISFACTION:** To improve our services, I routinely conduct client satisfaction surveys, and follow up (after treatment) surveys. If you do not wish to participate, or be contacted for this purpose please let me know. Signing this agreement is your permission for me to contact you for this purpose. Your help in completing the surveys and providing feedback about your treatment experience is greatly appreciated.

**EMAILING LIST:** I would like to add you to my emailing list. Your email address will be kept confidential, and only used to send you my newsletter or other information that may be of interest to you. At any time you are free to “unsubscribe.” By providing your email address in the space below, you are giving me permission to add you to my list and periodically send you information.

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Your email address

**CONSENT FOR TREATMENT:** I voluntarily agree to the conditions and terms of our psychotherapist/client relationship as set forth above. I agree to discuss my treatment options with the above named therapist at my initial visit and after. I hereby consent to, and authorize the giving of all treatment, which, in the judgment of the above therapist, may be considered necessary or advisable for the diagnosis, or treatment to the below named client. I voluntarily agree to this treatment and understand that I can withdraw from treatment at any time without penalty of any sort. No specific promises or guarantees have been made to me by the above therapist about the results of treatment, effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.

I, \_\_\_\_\_, have read and understand this agreement, and agree  
(print name)  
to the terms as stated. I have had an opportunity to ask questions about this agreement. I have been given a copy of this agreement:

\_\_\_\_\_  
Clients' name printed

\_\_\_\_\_  
Clients' Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible party (if different from above)

\_\_\_\_\_  
Date

If there is an emergency during our work together, or I become concerned about your safety or about you harming someone else, I am required by law to notify someone close to you. Please write down the name and information of your chosen contact person below:

Name: \_\_\_\_\_ relationship: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
Phone #: \_\_\_\_\_

**FINANCIAL POLICY AGREEMENT**

I understand that I am responsible for all charges, including payment for late cancel or missed appointments, regardless of my insurance coverage. Insurance will not cover late canceled or missed appointments.

I give Scherry Messic, Ph.D. permission to release any information obtained during examinations or treatment that is necessary to support any insurance claims on this account and secure timely payments due to the assignee (Dr. Messic) or myself.

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to Scherry Messic, Ph.D., for claims on this account.

I understand I will be charged for appointments not canceled 24 full hours in advance. If I have any question about being able to keep a scheduled appointment, I agree to notify Dr. Messic at least 24 full hours or more in advance.

I agree to have my credit card charged for any missed appointment or appointment cancelled with less than 24 hours notice.

I understand that my financial information may be released without my consent to a collection agency, attorney, or small claims court if I am delinquent in paying my account.

I have read, understand and agree to the above conditions and fees. I agree to pay all charges incurred by me or family members who receive services from Scherry Messic, Ph.D., including those not covered by insurance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

# CREDIT CARD AUTHORIZATION FORM

Please fill this form out completely and fax to (619) 393-0116.

Customer Section ( Please print clearly )		
Name on Credit Card		
<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> American Express		
Credit Card #		
Expiration Date		
3 or 4-Digit Security Code*		
<p> <input type="checkbox"/> Visa or Master Card (3 digits on back of card)      <input type="checkbox"/> *Amex (4 digits on front of card) </p> <p style="text-align: center;">1234 5</p>		
<b>Credit Card Customer Service phone number: (Found on the back of the card)</b>		
<b>Credit Card Billing Address (The address your credit card company mails to you)</b>		
Address		
City, State,		
Amount to be	\$	
<b>I authorize Scherry Messic, PhD, to charge my credit card account for the amount listed above.</b>		
Signature:	Date:	
<b>Office Use Only:</b>		
Sales	Quote# / Order	7