Coral Compagnoni, LMFT

Licensed Marriage and Family Therapist # 84799
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Client Statement of Understanding & Consent for Treatment

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask any questions that you may have regarding its content.

1. About the Therapy Process: Therapy is more of an art than a science. It is a process based on a very special partnership between the therapist and the client. It is the therapist's intention to provide services that will assist you in reaching your goals. You have the right to determine your treatment goals, and during the course of therapy you may change or add goals. Based upon the information that you provide and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. The therapist and the client are partners in the therapeutic process. You have the right to agree or disagree with therapeutic recommendations.

Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Such benefits may also require substantial effort on your part, including an active participation in the therapeutic process, honesty, and openness in order to change. Your therapist will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy. During therapy, remembering or talking about painful memories, unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings. Attempting to resolve issues that brought you to therapy, such as personal or interpersonal relationships, may result in changes that were not originally intended. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. 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 you progress in therapy with your therapist. There is no guarantee that psychotherapy will yield positive or intended results.

You may get "home assignments" after a session. These may involve such things as reading, writing, discussing, visualizing, doing a specific exercise, or practicing a new behavior. Please make sure you understand each assignment. If you do not remember or understand the assignment when you go to do it, please call your therapist for clarification.

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

2. Therapist's Status: The psychotherapy you will receive will be provided by a Marriage and Family Therapist (LMFT) licensed by the Board of Behavioral Sciences in the State of California (Lic. # 84799). Therapist is a sole practitioner and not part of a group practice. Any other mental health professionals in the same office suite as therapist are unrelated in any business manner, even though they share office space.

3. Confidentiality & Its Limits: Everything discussed in session will be held in strictest confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) in the treatment unit who are competent to execute the release provide their written authorization to release information. **However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family and couples therapy.** This means that if you participate in family and/or couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had, when working with other members of your family. Please feel free to ask your therapist about the "no secrets" policy and how it may apply to you.

In accordance with state and federal laws, there are instances when your therapist is permitted and/or mandated to break confidentiality without your written consent. The law permits/mandates therapists to break confidentiality and report required information to the appropriate authorities under the following circumstances, or as may be required by a court order:

1) When the client is thought to be in danger of committing suicide.
2) When there is reasonable suspicion of child, dependent, or elder abuse.
3) When the client threatens serious harm to someone.

4. Confidentiality of E-mail, Texts, & Cell Phone Communication: It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. 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. Please notify your therapist at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices.

5. Consultation: Your therapist may consult with other professionals regarding their clients; however, the client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained. This is done to provide you with the best care possible.

6. Fees: Payment for therapy is due at the time of the appointment. The agreed upon fee per 60-minute psychotherapy session is $120. Acceptable forms of payment are cash, check, or credit card. Please make checks payable to "Coral Compagnoni, LMFT".

This fee will not be increased within the next 6-months. If the fees are increased after that time and you are still in treatment, you will receive 30 days notice before the increase.

Alternative Fee Agreement: I agree to pay $_____ per 60-minute session.
Notes about Alternative Fee Agreement: _____

7. Cancellations & Missed Sessions: There is a 24-hour notice to cancel or reschedule visits. You will be charged for visits that you miss, cancel, or reschedule with less than 24 hours notice. Exceptions are illness, medical emergencies (such as hospitalizations), and natural disasters.

Client Initials: _____

8. Therapist Availability/Emergencies: Therapist will provide you with her business card so that you have her contact information. Telephone consultations between office visits are welcome. However, therapist will attempt to keep those communications brief due to the belief that important issues are better addressed in regularly scheduled, in-person sessions. Should you wish to talk over the phone, the first 5 minutes are free of charge. All subsequent time will be billed at your per minute session rate. You may leave a message at any time on therapist's voicemail. If you wish a return call, please indicate that on your message and be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. You should be aware that your therapist will generally return phone calls within 24 hours.

If you have an urgent need to speak with your therapist, please indicate that fact in your message.

In the case of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

9. Termination of Therapy: You have the right to terminate therapy at any time. That said, it is a good idea to plan for your termination in collaboration with your therapist. Once you feel your goals have been met and you decide you would like to end therapy, your therapist will discuss a plan for termination with you.

I have read and understand the above statement of services provided by Coral Compagnoni, LMFT. The above information was discussed with my therapist during the first counseling session and I consent to treatment.

_____ Date:_____
Client's Printed Name Client's Signature

_____ Date:_____
Client's Printed Name Client's Signature

Therapist Signature: _____ Date:_____
Coral Compagnoni, LMFT

Client was offered a copy of this consent on _____. Client ___Accepted _____Declined.
(Date)

Rev. 8/18/15

Client Initials: _____