Elizabeth Ramírez Child &
Family Counseling, Inc.
www.elizabethramirezmft.com

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831-754-3077

DISCLOSURE STATEMENT

The therapeutic relationship is unique in that it is highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me at any time during treatment.

About Treatment: Benefits, Risks, and Alternatives

Psychotherapy can be a helpful service to many people. Reaching counseling goals is an individual experience varying in treatment approach and duration. Some outcomes to psychotherapy include self-exploration, gaining understanding, resolving past harmful experiences, finding new ways for dealing with problems, and learning new skills.

The benefits of psychotherapy are often reached through experiencing a complexity of emotions and review of life issues. This is part of the therapeutic process and often provides the basis for transformation. Significant personal decisions are often a result of therapy and may be experienced within behavior, relationships or employment.

Willingness and candid participation assist towards a beneficial outcome in your treatment. You may benefit from therapy when there is honest participation.

In signing this disclosure, you are agreeing to a "***No Secrets Policy***" between members of a treatment unit such as families and couples. When I receive non-patients as part of the treatment, that person(s) should not have an expectation of confidentiality but has the right to privacy. I would have to assert privilege on behalf of the person.

I use a relationship-focused approach including self-awareness and skill building towards having a more complete sense of self. Treatment is planned with agreed upon goals after a thorough assessment. It may take more than the initial session to mutually decide on the treatment. I will inform you of my treatment approach. I will refer you to three other therapists to continue your counseling process if necessary.

Treatment of Minors

I prefer treating minors with signed consent from parents or legal guardians. I will make the effort to contact both parents to provide the best treatment. In the case of a divorce or separation, I request a copy of the current custody order and any other related documents.

I maintain a child's privacy during their counseling process. I provide general information about the treatment for parents/guardians to understand the services. When I deem it necessary, I may discuss with the child the importance of sharing information with their parents or guardians.

I collaborate with parents for the best interest of the child. I request parents/guardians participate as needed during the child's treatment. This could include individual conversations, parenting sessions or family sessions. We will determine the appropriate participation throughout the therapy treatment.

Contacting Me

My appointment availability is Monday through Friday, generally 9am to 5pm. **Urgent calls will be returned within 24 hours.** You can leave a voicemail, text message, e-mail messages and use Secure Messaging at any time: 831-754-3077, e-mail: elramirezmft@gmail.com, Secure Messaging through Simple Practice.

Emergencies

In a ***psychological emergency*** call 911 or go to the nearest hospital emergency room including: Salinas Natividad Crisis Team, 831-755-4111 or Monterey Peninsula Community Crisis Team (CHOMP), 831-625-4623.

When I am out of the office for an extended time, we will prepare for the gap in sessions or another mental health professional may cover my practice. We will develop a plan that meets your needs.

Communication Policy

Email and text messaging

E-mail communication and text messaging are not appropriate for discussion of sensitive topics. I prefer to limit the use of e-mail or text messages to the purpose of scheduling, confirming or changing appointments or questions that do not involve sensitive topics.

Potential risks of electronic communication may include but are not limited to inadvertent delivery of confidential information to the wrong recipient, theft or loss of the computer, laptop or mobile device storing confidential information, and interception by an unauthorized third party through an unsecured network. E-mail and text messages may contain viruses or other defects and it is your responsibility to ensure that they are virus-free.

Social Media Platforms

I will not accept "***friend***" requests or similar connections with clients, or their family members or friends, on social media. This is to protect your confidentiality and privacy. If you are interested in "***Liking***" my professional Facebook page or to "***Follow***" me on Twitter, you may do so at your own risk. Please note that social media platforms are not an option to contact me, especially in an emergency.

If you would like me to review your (or your child's) social media interactions as part of our therapeutic work, please print what you would like me to review and bring it with you to the session. Even if you or your child's media accounts are public, I will not examine them without your specific consent and direction.

Please note that any social media apps you use may seek to connect you with me or with other visitors to this office through a "***people you may know***" or similar feature. I have no control over apps that may intrude on the privacy of your treatment in this way. If you would like to minimize the risk of others becoming aware of your connection to me or this office, please make use of the privacy controls available on your mobile device. Turning off a social media app's ability to know your location, and refusing access to your email account and the contacts and history in your mobile device protect your privacy and confidentiality.

Confidentiality

Information disclosed within psychotherapy sessions is generally confidential and will require your written permission to release. If you participate in marital or family therapy, I only disclose confidential information about your treatment when all person(s) who participated in treatment provide their written authorization to release such information. I will discuss consultation with other health care professionals when appropriate. I respond to subpoenas as required by law or when an applicable legal or ethical exception exists. I am a treating psychotherapist and do not provide services in contemplation of legal proceedings nor psychological evaluations. However, if I do respond to a subpoena, I bill according to a total of all time and costs related to responding. Questions regarding legal issues should be discussed with your attorney.

I am required to report suspected child, elder, or dependant adult abuse and any situation where the client threatens violence to an identifiable victim. The law also permits me to break confidentially when the client presents a danger to self unless protective measures are taken.

Appointment Scheduling

If you cancel or miss appointments it is your responsibility to reschedule. I am unable to guarantee future sessions if there are numerous gaps in treatment such as frequently missed appointments or late cancellations. Appointments cancelled with less than ***48-hours' notice*** will have a ***missed appointment fee*** equal to the total cost of the session.

CCAH/MediCal/Beacon Health Options Coverage – if there are frequently missed appointments and/or late cancellations, there is not a fee assigned. However, I will not guarantee future sessions.

Fees and Billing

Fees are collected at each session. The fees vary based on the use of a third party or paying the cost yourself. I may make fee arrangements with clients on a case-by-case basis. Telephone calls over 15 minutes will be prorated at the session rate. My typical cost is $120.00 per session.

Your cost: _____/per session ***Total cost: _____ /per session*** *(may differ based on third party payor)*

Third Party Service Coverage and Payments

You are responsible for obtaining any necessary authorization from your third party payor. I will submit claims to the insurance plan or third party payor. You are responsible for copayment/coinsurance and deductibles as set by your benefit plan. ***Missed appointments*** are not covered by all insurance plans and the charges associated with them may be your responsibility.

You are responsible for 100% of the cost of services. At any time during treatement should your eligibility or coverage change, please notify me as soon as possible.

Finalize Treatment

It is a good idea to plan together for termination of the counseling treatment. If it determine you are not benefiting from your work with me or if your concern is outside my scope of competence, I may refer you to other professional services that may better meet your needs.

Treatment may also be terminated if the conditions of treatment are not met. These include not collaborating with the mutually agreed upon treatment goals, frequent cancellations, missed appointments or failure to pay.

Acknowledgement

I have been informed and hereby acknowledge that Elizabeth Ramirez Child and Family Counseling, Inc. is in private practice.

I have reviewed this disclosure. I understand and agree to abide by its contents, and I wish to participate in treatment. I have received a copy of this disclosure.

_____

CLIENT Signature (Parent/Guardian if minor) Date

Third Party Payer Authorizations

I authorize the third-party services (i.e., insurance plan, EAP, Victims of Crime) to directly pay Elizabeth Ramírez Child & Family Counseling, Inc., for services rendered.

_____

CLIENT Signature (Parent/Guardian if minor) Date

I authorize Elizabeth Ramírez Child & Family Counseling, Inc. to contact the third-party services (i.e., insurance plan, EAP, Victims of Crime) in order to facilitate payment for services rendered.

_____

CLIENT Signature (Parent/Guardian if minor) Date

Notice of Privacy Policy

The "*Notice of Privacy Practices"* provides the policy about your protected health information. I encourage you to read it in full.

I have received a copy of the notice and am aware it is available on the website: www.elizabethramirezmft.com.

Initial to acknowledge receipt _____

Initial the preferred communication methods:

Phone calls ___ Text Messages ___ E-mail Messages ___ Post Mail ___ Secure Messaging: ___ Other: ____

I have discussed the issues herein with the client. My observations of this person give me reason to believe that he/she is competent to give informed and willing consent to psychotherapy treatment.

_____

THERAPIST Signature Date