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

ELIZABETH RAMIREZ
Marriage & Family Therapist

DISCLOSURE STATEMENT

The therapeutic relationship is unique in that it is a 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, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me.

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 reviewing 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 behaviors, 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 between client and therapist.

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 client treatment, that person(s) should not have an expectation of confidentiality but have 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 both 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. 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 course throughout the therapy treatment.

Contacting Me

My appointment availability is generally Monday through Thursday, 9am to 5pm. I am unable to guarantee availability on Fridays and weekends. Calls received on Fridays will be returned on the following Monday. **Urgent calls will be returned within 24 hours.** You can leave a voicemail, text message and e-mail message at any time. Phone: 831-754-3077, e-mail: elramirezmft@gmail.com.

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 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.

E-mail Communication and Text Messaging

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

Potential risks of electronic communication and text messaging 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.

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 do 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.

Indicate the preferred communication methods with your initials:

Phone calls	……..	Text Messages	……
E-mail Messages	……..	Fax	……..
Post Mail	……..	Other: _____	.....

Appointment Scheduling
If you cancel or miss appointments it is your responsibility to reschedule. The regularly scheduled appointment will not be held for you. 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-hour notice** will have a **missed appointment fee** equal to the total cost of the session.

Clients with CCAH/MediCal/Beacon Health Options – 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 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

Third Party Service Coverage and Payments

You are responsible for obtaining any necessary ***prior authorization*** for treatment from your third party service provider (insurance, EAP). I will submit claims for the therapy. However, you are responsible for copayment/coinsurance and deductibles as set by your benefit plan. ***Missed appointments*** are not covered by insurance plans and the charges associated with them are your responsibility.

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

Finalize Treatment

It is a good idea to plan for termination of counseling treatment between the client and myself. If it appears to me that you are not benefiting from your work with me or if your problem is outside my scope of competence, I may refer you to 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, Marriage Family Therapist 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 (insurance, EAP, Victims of Crime) to directly pay Elizabeth L. Ramírez, MFT for services rendered.

_____
CLIENT Signature (Parent/Guardian if minor) Date

I authorize Elizabeth L. Ramírez to make any contact necessary with the third-party services (insurance, EAP, Victims of Crime) in order to facilitate payment for services rendered.

_____
CLIENT Signature (Parent/Guardian if minor) Date

Notice of Privacy Policy
My "*Notice of Privacy Practices"* provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

I have received a copy of the notice.
Initial to acknowledge receipt _____

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

_____
THERAPIST Signature Date