Kym Lundberg, MFT Associate
Intern # IMF95251
Supervised by Rebekah Balboni, LMSW
License # 24270

CLIENT INFORMATION AND CONSENT

Welcome to my practice. Please feel free to ask me any questions or let me know of any concerns you have about the process of therapy. In order for the agreements between us to be clear, I want to let you know some things regarding my policies and procedures. Please tell me if anything is unclear to you. I look forward to working together.

Appointments: I usually schedule appointments with clients on a regular basis and once we agree on a time, I will reserve that space for you from one week to the next unless we have made other arrangements together.

Cancellation: I have a 24-hour cancellation policy in my practice. This means that if you are unable to come to an appointment, you need to let me know at least 24 hours in advance. If an emergency prevents you from coming, I will try to reschedule our appointment for the same week, if at all possible. Missing an appointment without prior notification will result in a charge to you of your customary fee or, if you are covered under a managed care policy, my contracted fee with your managed care company for the scheduled service that was missed. In addition, missing more than 2 appointments without prior notification or missing frequent appointments with notification may result in termination of services.

Fees: My fee for a 60-minute session is $. Pro-rated fees are available for longer sessions, if desired. Lower fees on a sliding-scale, based on income, are available for qualified individuals. We have agreed to a fee of _____per session, which is payable at each session unless we have agreed to a different option. Phone calls with clients and for treatment collateral purposes that are over 10 minutes in length will be charged at pro-rated fees based upon my $ per 60 minute fee (ie: a minute phone call will cost $).

Insurance: If I am a preferred provider for your insurance company, I will submit bills on your behalf, and your co-pay will be due at each session. You are responsible for notifying me if your insurance lapses or changes, and providing a copy of your insurance card(s). Most insurance companies require frequent updates on symptoms and progress in order to authorize additional sessions. There may also be limits on how many sessions are allowed each year. Please review your insurance plan for this information. I expect your insurance company to pay, but if a claim is denied, payment is ultimately your responsibility. If your maximum number of visits according your insurance policy have been reached and you wish to continue treatment, you may do so at your own cost and we can discuss payment rates at that time.

Contacting Me: I try to return phone calls within 24 hours. If you call during the weekend, please let me know if it is urgent and I will do my best to call you back as soon as I receive your message. If you are in crisis and it is hard to wait for my return call, please remember that you can call the 24-hour crisis line: 1-800 309-2131 for Alameda County or the California Youth Crisis Line 1-800-843-5200.

Confidentiality: What we discuss in therapy is confidential and cannot be shared with others without your consent. There are a few exceptions to this rule of confidentiality:

- If you make a serious threat to harm yourself or another person, the law requires me to try to protect you or that other person. This usually means telling others about the threat. I cannot promise never to tell others about threats you make.
- If I believe a child or elder has been or will be abused or neglected, I am legally required to report this to the authorities so they can intervene on behalf of that person.

Assessment and Treatment: I will provide an assessment of your difficulties and available treatment options. During the assessment period, we will explore if we are a good therapeutic fit for one another. If it appears that we are not a clinical match or your needs are out of my scope of practice, I will refer you to another provider. If I recommend we proceed with treatment, and you agree, I will provide psychotherapy for you. I will provide rationale for the psychotherapy approach or other treatment options I recommend for you. I will try to provide an estimate of the number of treatment sessions that it will take to achieve your treatment goals, although this is only an estimate. For most patients, treatment may range from 10-50 sessions. No guarantees can be made regarding the success of treatment. There is a small risk that your condition may worsen during treatment. Treatment can be time consuming and stressful. It can bring up many strong feelings. It may result in changes that were not originally intended. Treatment decisions for you will be made collaboratively between you and me.

Clinician Responsibilities: I am responsible for providing you with quality professional service. This includes treating you with respect, maintaining your confidentiality (see above), and informing you about your condition/diagnosis and treatment options. Information about treatment options will include potential benefits and risks associated with those options. In order to meet these responsibilities I may consult with other clinicians. This will be discussed with you.

Patient Responsibilities: You are expected to play an active role in your treatment with me. This includes working with me to outline treatment goals, be on time for appointments, provide 24-hour cancellation notice when unable to attend, and complete homework tasks between sessions. If at any time you are unhappy about the progress or outcome of your treatment, please discuss this with me so that we may attempt to resolve any difficulties and arrive at a treatment plan that better meets your needs.

Record Keeping: I maintain a clinical chart of handwritten notes for each patient. Information in this chart includes your name, contact information, diagnosis, description of your condition, treatment goals, treatment plan, dated progress notes from each session, symptom monitoring forms, and consent for release of information documents. These records are stored in a locked filing cabinet.

Substance Use: Please refrain from being under the influence of alcohol and/or illegal substances during the therapy session.

Release of Information: If using insurance for service, I authorize release of information for claims, certification/case management/quality improvement, and other purposes related to the benefits of my Health Plan.

Statement of Client Consent: I have read and understand the policies described above and agree to begin therapy with Kym Lundberg. I am aware that I may stop therapy at any time.

_____ _____

Signature of Client (or Parent/Guardian) Date

_____ _____

Signature of Client (or Parent/Guardian) Date

_____

Printed Name of Client

_____ _____

Signature of Therapist Date