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**Miki Hawkins, MFT** P.O. Box 3521

**Marriage Family Therapist**  Yuba City, CA 95992

**LMFT# 40691** 530-300-4059

# EVALUATION/TREATMENT AGREEMENT

In preparation for our initial appointment, please read the following and bring it with you to our first meeting. I have outlined my routine office procedures for you. Please ask any questions you may have about these policies or procedures during our initial session.

**\_\_\_\_\_THERAPY PROCESS:** Psychotherapy may include diagnostic services: individual, group, marital, or family therapy. Counseling is a process in which we talk about things in life. I will sometimes give feedback, direction or guidance. At times the process may become uncomfortable before things get better. There are varying degrees of success. Together, you and I will decide on frequency and types of treatment. Maximum benefits occur with regular attendance. Participation in counseling is voluntary.

**\_\_\_\_\_APPOINTMENTS:** Appointment sessions last forty-five (45) minutes. Appointment times and frequencies will be negotiated after the initial assessment. Since the scheduling of an appointment involves the reservation of time specifically for you, you will be billed for any appointment canceled without 24 hours prior notice. However, rescheduled appointments within the same week will be charged in lieu of the canceled appointment. Exceptions are made when circumstances are beyond your control. If rescheduling occurs frequently, you may be charged for missed appointments.

**\_\_\_\_\_FEES:** My current45-50 min. session rate is $110.00. The rate for the initial assessment is $130.00. The rate for Couples and/or Family Therapy is $130.00. It is the responsibility of the client to pay his/her bill on a regular basis, at the scheduled appointment time. It is the responsibility of each client to know or find out the filing requirements of their individual insurance company or managed care firm. Upon your request, I will provide a monthly statement of services. Your signature below authorizes me (Miki Hawkins, MFT) to furnish said parties all information requested concerning counseling services rendered.

Telephone consultations, which are five minutes or more in duration, will be billed in increments of fifteen minutes, with a fifteen-minute minimum. Clients are responsible for paying for telephone consultations at the next session. Additionally, letters, reports and collateral services will be billed at standard rate.

A service fee of 1.5% per month will be applied to all accounts with an unpaid balance. Should it become necessary to use the services of a collection agency, due to non-payment of an account, I understand that confidentiality regarding my having been a client will be waived.

**\_\_\_\_\_CONFIDENTIALITY:** Everything related to your assessment and/or treatment here is confidential. Information will not be given to anyone without your informed, written authorization or authorization from the parent or guardian, when applicable. The only exceptions to confidentiality are noted in law and governed by the ethics of my profession:

**\_\_\_\_\_**If there is threat of harm to another person; I am required to notify law enforcement agencies and intended victim.

**\_\_\_\_\_**If there is threat of harm to yourself; I may contact others to prevent the threatened harm. Hospital treatment may be necessary.

**\_\_\_\_\_**If, in my contact with you, I learn that any child or elderly person has been abused or neglected, I am required by law to report this to the appropriate agency.

**\_\_\_\_\_**Under certain circumstances (i.e., you claim a mental injury or mental disability), a Judge in a court of law may order me to release information.

**\_\_\_\_\_**I will disclose to your health care insurer only the minimal information necessary for approval of your bill.

Your signature indicates that you have read and understand the procedures described above.

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Signature (Relationship to Client) Date Signature of Minor/Client Date

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Witness