Informed Consent

Disclosure Statement & Agreement for Services

(for your records)

Introduction

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 you may have regarding its contents.

Information about your Therapist

I am a licensed Marriage and Family Therapist. I believe that therapy should be tailored to each individual's needs. I use various therapeutic modalities including Cognitive Behavioral Therapy (CBT), Solution Focused Therapy, Multi- Generational Therapy, Structural Therapy, Client Centered/Play Therapy and Family Therapy. I have found that using multiple interventions and structures helps to provide what is necessary to make positive and lasting changes. I have experience in numerous settings working with children through teenagers, adults and the older adult population.

If you have further questions about my background, experience and professional orientation, please let me know.

Fees & Insurance

Individual therapy sessions are $95.00 per 50-minute session.
Couples sessions are $95.00 per 50-minute session.
Family sessions are $125.00 per 75-minute session.

I currently accept cash or checks which will be due prior to session start. You may also pay by credit card/debit card through my website at www.kristykirby.com and click on the Payment tab. Please pay prior to session start. If a charge or a check is not honored by your bank, please be aware that any additional charges for the returned items will be your responsibility.

Services may be covered in full or in part by your health insurance or employee benefit plan. I will provide a receipt for services that you can submit to your insurance company for reimbursement. Please check with your insurance company to determine your benefits and reimbursement rates as this will vary.

If you are using insurance or an EAP, please check to make sure that I am authorized to bill on your behalf. You will need to fill out an Authorization to Release Information form so that I may speak with the insurance company regarding your sessions. Please note that if you are using a third party, some information will not be confidential such as diagnosis and treatment issues. If you have questions about this please let me know.

If for some reason you find that you are unable to continue paying for your therapy, please let me know. We can discuss the options available to you including possible reduced rates for services or referrals for low income services.

Confidentiality & Privacy Policy

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. However, it is important that you know that I utilize a "no-secrets" policy when conducting family or marital/couples counseling.

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child abuse, elder abuse or dependent adult abuse. Therapists may be required or permitted to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person or when a client is dangerous to him or herself. In addition, a federal law know as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the client that the FBI sought or obtained the items under the Act.

Please ask about any questions you have regarding confidentiality and exceptions to confidentiality.

Minors and Confidentiality

Communications between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, in the exercise of my professional judgment, I may discuss the treatment progress of a minor patient with the parent or caretaker. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest more or less therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify me at least 24 hours in advance of your appointment time. Please contact me at 707-365-9246**. If you do not notify me with at least 24 hours of the cancellation, you will be responsible for a $55.00 cancellation fee.** Please understand that you insurance company will not reimburse you for missed or cancelled sessions. A Credit Card Release, or undated check, will be required to keep on file after the first missed appointment.

Therapist Availability/Emergencies

Telephone consultations between office visits are welcome. However, I will attempt to keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions. You may leave a message for me at any time on my confidential voicemail. Please be sure to leave your name and phone number(s) along with a brief message concerning the nature of your call. Non urgent phone calls are returned during normal workdays within 24 hours. If you have an urgent need, please indicate that fact in your message and follow instructions that are provided in my voicemail message.

In the event of a psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please contact Solano County Crisis at 784-1131, or call 911.

Therapist Communications:
I may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

About the Therapy Process
It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

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

Termination of Therapy
The length of your treatment and the timing of the eventual termination of your treatment will depend on the specifics of your treatment plan and the progress you achieve. Planning your termination is something we will do in collaboration.

You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either you or I may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating therapy.

This is your copy; please read it carefully before signing.

Your signature indicates that you have read this agreement for services and understand its contents.

Please ask any questions or discuss concerns you may have about this information before you sign.

Signature Date

Signature (if more than one client) Date

Kristy Kirby, MFT #48653

I have read and understand the Informed Consent: Disclosure Statement & Agreement for Services.

I further understand that I am responsible for services even if my insurance does not cover the cost. I understand that I will be charged a $45.00 cancellation/no show fee for appointments not cancelled within 24 hours by phone, email, or text and that I may be required to keep a Credit Card Agreement on file to cover these costs.

I also have read about the Privacy Policies and Confidentiality and understand that my therapist is a mandated reported and certain information, by law, may be reported.

I also have been notified in this informed consent of whom to contact in case of a psychiatric emergency.

I know that it is my responsibility to contact my therapist for further clarification, questions or concerns regarding this document.

Primary Client Name **Signature**

Relationship to Client if client is a minor Date

____My therapist may call me at me home. My home phone number is: ( ) _____

____My therapist may call me on my cell phone. My cell phone number is ( ) _____

____My therapist can text me on the above number.

____My therapist may communicate with me by email. My email address is _____

____My therapist may send a fax to me. My fax number is ( ) _____

____I do not want my therapist to send information to my home address

Client Name (If more than one client) **Signature**

Relationship to Client Date

____My therapist may call me at me home. My home phone number is: ( ) _____

____My therapist may call me on my cell phone. My cell phone number is ( ) _____

____My therapist can text me on the above number.

____My therapist may communicate with me by email. My email address is _____

____My therapist may send a fax to me. My fax number is ( ) _____

____I do not want my therapist to send information to my home address