Robert “Bob” Engel, Licensed MFT #93164
Office: 101 Morris St., Suite 207, Sebastopol, CA 95472
Mail to: P.O. Box 388 - Graton, CA 95444
707-861-0441
bob@sebastopoltherapy.com

Client's Last Name _____

Office Policies and Agreement for Services

Our relationship as therapist and client is an authentic, personal and important one. It is also a relationship governed by legal and ethical standards which are detailed below.

Regarding confidentiality:

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law.

Some of the circumstances where disclosure is required by the law are:
- where there is a reasonable suspicion of child abuse or neglect
- where there is reasonable suspicion of dependent or elder abuse or neglect, including financial abuse
- where a client presents a danger to self, to others, to property, or is gravely disabled.

Other Times Disclosure May Be Required: If you place your mental status at issue in litigation initiated by you, or if you introduce your mental state to a legal proceeding, others may have the right to obtain the psychotherapy records and/or to have testimony from me.

Couples and Families: I will not release records to any outside party unless I am authorized to do so by all members of the treatment unit, including minors over 12 when appropriate.

“Secrets Policy:” I do not have a black-and-white policy regarding secrets between partners in a couple or members of a family. If one client in a treatment unit asks in confidence that information be withheld from another, I will use my clinical judgment about disclosure. I may choose to hold a secret for a time, while working towards disclosure when clinically appropriate, or I may insist on immediate disclosure (or termination) if there seems no way to provide appropriate therapy without doing so.

Emergencies: If there is an emergency during our work together, or in the future after termination, when I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided as an emergency contact.

Consultations: I take part in consultation groups. I protect client identities in these groups and these colleagues are also bound by confidentiality. If I consult with a colleague regarding the specifics of your case and need to reveal your identity, I will ask for a signed release.

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Regarding Insurance Coverage: If you have Medi-Cal coverage with Beacon/PHP, I can bill them for many individual mental health issues. Medi-Cal does not cover couples counseling. I do not bill private insurance carriers directly, but I will provide invoices that you can present to your insurance carrier. You are responsible to pay your fee at time of service, whether your carrier reimburses you or not. If you instruct me, I will provide your carrier with the minimum necessary information to verify you for coverage. It is your responsibility to know your insurance company’s policies including what they cover, what information they require and how they handle it. Bear in mind that some risk of disclosure may result when information is entered into insurance companies’ computers.

Communications:
If you need to contact me between sessions, please call (707) 861-0441. If you leave a message your call will be returned as soon as possible. My office phone is a cell phone which also sends me an email version. This enables me to keep in touch with clients efficiently, but also includes some risks. I suggest that you limit the information sent by any of these means and do not include overly personal information. I check my messages a few times a day (less frequently on week-ends). If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away, you can call the 24-hour crisis line (Psychiatric Emergency Services) at (707) 576-8181, or call 911.

Confidentiality of E-mail, Cell Phone and Texts: It is very important to be aware that text, e-mail and cell phone messages could be accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. If you need to discuss private, clinical information, let us do so in a phone conversation.

Payment and Fees: You are expected to pay the standard fee of $110 per 50-minute session at the beginning of each session. Telephone conversations of more than 10 minutes and longer sessions will be charged at the same rate, unless indicated and agreed otherwise. A sliding scale is available based on your income. Your fee is set at $_____. (Note: If your insurance fails to pay for sessions billed, you may still be liable.) Please give 24-hours notice or changes or cancellations. You may be required to pay for sessions missed without prior notice.

Dual Relationships: You and I may choose to work together clinically despite having a relationship outside of therapy if we agree that it can be clinically effective. Not all dual relationships are unethical or avoidable. It is your, the client’s, responsibility to communicate to me if the dual relationship becomes uncomfortable for you in any way. I will always listen carefully and respond accordingly to your feedback.
Additionally, Sebastopol is a small town and many clients know each other and me from the community. If we see one another in public, I will never greet you, because to do so might impinge on your confidentiality. You are free to greet me or not as you wish.

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The Therapeutic Process: I believe that the therapeutic relationship is a collaborative one. Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Psychotherapy requires your active involvement, honesty, and openness in order to explore and potentially alter your thoughts, feelings and/or behavior. This process can be challenging or even disturbing. Please be aware that meeting these challenges will help you to achieve your goals. I will ask for your feedback on your therapy and its progress and I trust you to respond openly and honestly. Despite your hopes and my intent, it must be said that there is no guarantee that psychotherapy will yield positive or intended results.

Note: I have been been trained in somatic techniques, meaning that body awareness, movement, breath, voice and sometimes touch may be used when appropriate and with permission. If at any time you have questions or concerns about this or any technique I employ, please share your concerns with me.

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and possible outcomes of treatment. If you have any questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask so that we can discuss. If you could benefit from any treatment that I do not provide, I will assist you in obtaining those treatments.

You have the right to terminate therapy at any time. At the end of therapy we will address goals met and meaningful experiences encountered. If you wish a referral to someone else, I will offer to provide you with names of qualified professionals whose services you might prefer.

I have read this three-page Agreement and Office Policies carefully and have received a copy. I understand this agreement and agree to comply with it:

Client name (print)	Date	Signature

Client name (print)	Date	Signature

Bob Engel, LMFT #93164	Date	Signature

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I have received a copy of the **Office Policies and Agreement for Services** and have been given an opportunity to review it before signing.

My therapist, Bob Engel, and I have discussed the basics of confidentiality as well as legal exceptions to confidentiality as outlined in the first paragraphs of this document.

I understand that the fee has been set at _____ per 50 minute session and that a 24 hour notice is required to cancel an appointment. (exceptions may be made for emergencies)

My therapist has discussed with me the potential benefits of having audio recordings of our sessions.

I agree to these recordings. _____ (initial)

Name (printed) Signature Date