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Alliance Therapy & Wellness
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Contract Agreement of Policies and Treatment

The following are my office policies, which I ask that you read carefully. Please feel free to ask any questions regarding the following:

CONFIDENTIALITY: As your therapist I maintain a strict policy of confidentiality to the full extent of the law. This means that your name, diagnosis & other personal information will not be disclosed without your prior written consent. According to California State Law, confidentiality is suspended under the following circumstances: (A) When a therapist has cause to suspect or believe that a patient may be abusing a child, dependent adult, or elder, the therapist must report the suspicion to a responsible agency; (B) When a therapist has reason to believe that a patient may seriously harm another person (s) or may inflict harm on him or herself, the therapist must take steps to insure that person's safety; (C) Whenever additionally required by law.

CONSENT FOR TREATMENT: The purpose of therapy is to look at and experience ways in which important areas of your life could be different. Different is not necessarily better. Sometimes patients will feel worse before feeling better. Hopefully, through therapy your range of choices may be increased so that your life can be more satisfying and productive. Your therapist will assist you in formulating your goals and strategies to reach these changes. Results are enhanced if you are willing to act in new ways and perhaps experience discomfort in the process of change. However, there may be no benefit to you from these services. Your progress will be continually evaluated and feedback provided to you, as well as information about alternate forms of therapy relevant to your needs.

CANCELLATIONS & MISSED APPOINTMENTS: A scheduled appointment means that time is reserved only for you. If an appointment for either individual or group therapy is missed or canceled with less than 24 hours notice, you will be billed for your normal scheduled fee. You are responsible for missed sessions.

EMERGENCY PROCEDURES: If your call is urgent, please use the beeper voice mail code. Please use this for true emergencies only. Your therapist can be reached by dialing

_____
(To be completed during intake session)

FEES: The fee for all outpatient services is $100 per 45 – 50 minute session, payable in full at each appointment, unless prior arrangements have been made. A $20.00 fee will be charged for returned checks. We wish to inform you that delinquent accounts are managed by a collection service.

I,
_____agree:
(Print Name)

□ To be responsible for all financial obligations incurred during the course of my treatment, or treatment for_____.
(Relationship)

□ To pay for missed or canceled appointments unless cancellation occurs a minimum of 24 hours before my scheduled meeting time.

I have read and understood all the above. (A copy will be provided upon request).

Signature(s)_____
_____

Witness _____

Date _____