CAITLIN R. BURGESS, JD, MA, LMFT
Professional Clinical, Legal, and Forensic Services

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AGREEMENT FOR SERVICE / INFORMED CONSENT

Introduction: This Agreement is intended to provide _____ (herein "Patient") with important information about the practices and policies of Caitlin R. Burgess, JD, MA, LMFT (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns about the contents of this Agreement should be discussed with Therapist prior to signing it.

Therapist Background and Qualifications: Therapist is a Licensed Marriage and Family Therapist in California (MFT #94485) and Washington (LF #61090853) with a Master's in Counseling Psychology.

Consultations & Supervision: Clinical services are provided by clinicians who are either currently licensed or who are in training to become licensed therapists. Clinicians who are in training are supervised by Caitlin R. Burgess (CA MFT #94485 and WA LF #61090853) on a weekly basis. During supervision meetings, your information may be discussed. All information shared between clinicians, supervisors and administration is handled confidentially within my practice.

Risks and Benefits of Therapy: Psychotherapy is a process in which Therapist and Patient discuss a myriad of issues, experiences and memories for the purpose of creating positive change so Patient can experience life more fully. It provides an opportunity to better and more deeply understand oneself and any difficulties one may be experiencing. Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular issues being addressed, as well as many other factors.

Therapy may result in a number of benefits to Patient, including but not limited to less stress/anxiety, fewer negative thoughts/behaviors, better relationships, more comfort in social/work/family settings, and more self-confidence. Such benefits may require substantial effort by Patient, including active participation in therapy, hones-

ty, and openness to change feelings/thoughts/behaviors. There is no guarantee therapy will yield any or all of the benefits above. It may involve some discomfort, including recalling and discussing unpleasant feelings/experiences, and may evoke strong feelings of sadness, anger, fear, etc. At times Therapist may challenge Patient's perceptions and offer different perspectives. Issues Patient presents may result in unintended outcomes, such as relationship change. Any decision as to his/her personal relationships is Patient's responsibility. During the therapy process, many find that they feel worse before they feel better; this is normal. Patient should discuss any concerns with Therapist.

Professional Consultation: Professional consultation is an important component of a healthy psychotherapy practice. Therapist regularly participates in clinical/ethical/legal consultation with appropriate professionals. In such consultations Therapist will not reveal any personally identifying information regarding Patient.

Records and Record-Keeping: Therapist will produce notes/records regarding Patient's treatment. These constitute Therapist's clinical and business records, which Therapist must maintain by law, and are the sole property of Therapist. Should Patient request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California and Washington law, to provide Patient with a treatment summary in lieu of actual records. Therapist also may refuse to produce a copy of the record under certain circumstances but may, as requested, provide a copy of the record to another treating healthcare provider. Therapist will keep Patient's records for 10 years after termination of therapy. Patient's records will then be destroyed in a manner preserving Patient's confidentiality.

Confidentiality: The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law. Exceptions to confidentiality include but are not limited to reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.

Patient Litigation: Therapist will not voluntarily participate in any litigation or custody dispute in which Patient and anyone else are parties. Therapist has a policy of not communicating with Patient's attorney and will generally not write or sign letters, reports, or declarations to be used in Patient's legal matter, and will generally not

provide records or testimony unless compelled to do so. If Therapist is subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Patient agrees to reimburse Therapist for time spent for preparation, travel, or other time in which Therapist has made herself available for such appearance at the fee agreed upon by Therapist and Patient.

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Psychotherapist-Patient Privilege: The information disclosed by Patient and any records created are subject to the psychotherapist-patient privilege under the law, akin to the attorney-client or doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist is subpoenaed for records or deposition or court testimony, Therapist will assert the privilege on Patient's behalf until instructed in writing to do otherwise by Patient or Patient's representative. Patient should be aware that he/she may be waiving psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient should address any concerns regarding the psychotherapist-patient privilege with his/her attorney.

Fee and Fee Arrangements: The therapist and the patient have agreed upon a fee for therapeutic services prior to the first session. Longer sessions may be charged pro rata. Therapist reserves the right to periodically adjust this fee and will notify Patient in advance of a fee adjustment. The fee may also be adjusted by contract with insurance or managed care organizations or by agreement with Therapist. Patient is to pay for services at time rendered, by cash, check, credit or debit card. Occasionally Therapist may speak by phone with Patient for purposes other than session scheduling. Patient will pay the agreed-upon fee (on a pro-rata basis) for calls longer than three minutes. In addition, Patient will pay the agreed-upon fee (on a pro-rata basis) in three-minute increments for collateral services including but not limited to time spent reviewing documents, receiving and responding to correspondence (such as emails), and time talking with other professionals involved in your case.

Insurance: I am an out-of-network provider for all insurance companies. If Patient wishes to use his/her insurance, Therapist will provide Patient with a monthly state-

ment which Patient can submit to a third-party payor to seek reimbursement of fees already paid. Because all insurance plans are different in terms of the level of coverage provided for out-of-network services, it is recommended that you check with your insurance company to determine how much you will be reimbursed if you choose to work with me.

Victims of Crime Compensation Program: I accept compensation through the Santa Clara County District Attorney's Office Victims of Crime.

Cancellation Policy: Patient is responsible for payment of the agreed-upon fee for missed ("no-show") session(s) or any session(s) for which Patient failed to give Therapist at least 24 hours' notice of cancellation. Cancellation notice should be left on Therapist's voicemail at (831) 272-4299 or by text or email: info@caitlinburgess.com.

Therapist Availability: Therapist has a confidential voicemail system and Patient may leave a message at any time. Therapist will make every effort to return calls within 24 hours, but cannot guarantee calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. If Patient is feeling unsafe or needs immediate medical or psychiatric evaluation, he/she should call 911 or go to the nearest emergency room.

Termination of Therapy: Therapist reserves the right to terminate therapy at her discretion, for reasons including but not limited to untimely fee payment, noncompliance with treatment recommendations, conflict of interest, failure to participate in therapy, or Patient needs being outside Therapist's scope of practice or competence. Patient also has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate, Therapist will usually recommend Patient participate in at least one termination session to facilitate a positive termination experience and allow both parties to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient.

Acknowledgment: By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed the terms and conditions with Therapist, and any questions have been answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

CREDIT CARD AGREEMENT:

Please Note: New clients are requested to keep a valid credit card number on file. Please complete the following information and provide your credit card to your clinician at your initial session. This is set up for your convenience.

Credit Card Type: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Name as shown on card: _____

Credit Card Number: _____ Expiration date: _____

3-digit security code on back of the card: _____

If American Express, 4-digit code on front of the card: _____

Billing Address associated with this credit/debit card:

_____

Email Address: _____

This card may be charged for:

- Regular session fees (at your request, as a convenience to you)
- Fees for same-day cancellation
- Fees for cancellation without 24-hour notice
- Delinquent session fees (fees more than 30 days overdue)
- Document review (including emails, Court records, and correspondence) (charged in three-minute increments)
- Phone calls over ten minutes (with clients and collateral contacts) (charged in three-minute increments)
- I understand there are no refunds given

Please enter the agreed upon fee between Therapist and Patient below:

The agreed-upon fee is $_____ per 50-minute clinical hour.

"I _____ have read and understand the terms of providing my credit card to Caitlin R. Burgess, JD, MA, LMFT. I understand that my credit card may be charged for the reasons indicated above. I also understand there are no refunds given. Any questions I have about this practice have been answered and I give my full consent to charge my credit card under the circumstances checked above."

Your Signature Consenting to Charges: _____

Today's date: _____

This credit card agreement is valid for one year beyond today's date or until termination of services.