

DR. SHEILA M. ADDISON

Licensed Marriage and Family Therapist ♦ LMFT #49616
1900 Addison St., Suite 200 ♦ Berkeley, CA 94704 ♦ (510) 599-5467
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DISCLOSURE STATEMENT AND CONSENT FOR THERAPY

1. I have a master's degree (MA) and doctorate (PhD) in Marriage and Family Therapy from Syracuse University.
2. I am a Licensed Marriage and Family Therapist (MFC) in the state of California. I am also a Clinical Fellow of the American Association of Marriage and Family Therapists (AAMFT) and its California division (AAMFT-CA). I am an AAMFT Approved Supervisor as well.
3. The California Board of Behavioral Sciences (BBS) has the general responsibility of regulating the practice of Licensed Marriage and Family Therapists.

Board of Behavioral Sciences
1625 N Market Blvd., Suite S-200
Sacramento, CA 95834
(916) 574-7830
<http://www.bbs.ca.gov>

4. Client rights and important information:
 - a. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure. Please ask if you would like this information.
 - b. You have the right to terminate therapy at any time.
 - c. Generally speaking, your therapy with me is confidential and protected by law. I can release information about you and your therapy only with your written permission.
 - d. There are exceptions to the general rule of confidentiality. These exceptions include intent to harm yourself or others; abuse or suspected abuse of children or vulnerable adults; exposure to child pornography; neglect or suspected neglect of children or vulnerable adults; court-ordered therapy; subpoenaed testimony in criminal court cases; and orders to violate privilege by a judge.
 - e. Minors under age 18 should know that the law may provide your parents with the right to access your treatment records.
 - f. In marriage and family therapy, all members of the couple or family are treated as clients. I generally avoid keeping "secrets" from other members of the couple or family, except in cases where immediate disclosure would present a safety risk. However, I reserve the right to use my best clinical judgment, which usually means family members are encouraged to raise issues and disclose information themselves. Be sure to discuss any questions or concerns you have about this with me.

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- g. As an LMFT, I am a “mandated reporter” in the State of California. I am required to report knowledge or suspicion of abuse or neglect of minor children, elderly adults, and disabled or otherwise vulnerable adults. I am also required to report any admission of viewing or possessing child pornography.
 - h. Also, under California law, if you appear to be a serious danger to yourself or others, or you are gravely disabled, I may be required to break confidentiality. Such actions may include reporting threats to law enforcement, warning a possible victim, or requesting evaluation by a trained crisis team.
 - i. In a professional relationship (such as ours), sexual intimacy between a therapist and client is never appropriate.
5. My usual fee for psychotherapy is \$180 for a 50-55 minute session. Sessions running longer will be pro-rated accordingly. I charge this amount on a pro-rated basis for other services you may require, such as attendance at meetings or consultations with other professionals that you have authorized. Brief phone calls are not charged; I generally do not do phone sessions but a longer phone call in an emergency will be charged my pro-rated session fee. I charge \$75 for preparation of written treatment summaries. I evaluate fees once a year in January, and will notify you at least 30 days in advance if I anticipate a fee increase.
6. Payment for therapy services is expected at each session. Checks or other payment methods not honored by my bank when presented will result in charges equal to the charges assessed by my bank for a returned item, plus a \$35 service fee. In rare cases, I may need to take legal steps to deal with delinquent fees. In such a case, I would protect your confidentiality by describing my services as “consultation.” If we have made an arrangement to bill a third party payer (such as insurance or a family member) for services, and for any reason they do not pay for sessions that have taken place, you are responsible for payment.
7. Cancellation policy: I require 24 hours notice for a cancellation or I will request payment for the session. Exceptions may be made on a case-by-case basis for serious illness or injury suffered by you or a family member. You may email or phone me to cancel or reschedule.
8. Results of therapy are not guaranteed. Exploring issues in therapy may sometimes make problems feel worse rather than better. This is a normal part of even successful therapy, and I hope you’ll let me know if this happens so we can talk about how to stay safe and manage the feelings and issues that therapy brings up.
9. Court testimony on your behalf is charged at a higher rate of \$300 an hour. This includes travel, testimony, report writing and waiting time.

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- 10. There may be times when I need to consult with a colleague, supervisor, or another professional such as an attorney, about issues raised by clients in therapy. I will protect your confidentiality at all times. Signing this consent form gives me permission to consult as needed in order to provide high-quality professional services to you as the client.
- 11. I provide non-emergency therapy services by scheduled appointment. If you are having a true emergency involving your safety or general well-being, please call 911, call a local crisis hotline, or go to the nearest hospital emergency room.
- 12. If I expect to be unreachable for a planned period of time, I will provide you with options for interim services in advance if you request them.
- 13. Please see additional information contained in my Social Media Policy.
- 14. If you have any questions or would like additional information, please feel free to ask at any time.

CLIENT SIGNATURE, ACKNOWLEDGEMENT, AGREEMENT, AND CONSENT

I have read the preceding information and I understand my rights as a client. By signing below, I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. By signing this disclosure statement, I also agree to permit consultation, and I provide release for my therapist to seek consultation with other psychotherapists or professionals as the need arises. If I am an adult seeking treatment for a minor child/children, I affirm that I have the legal right to consent to such treatment, and I affirm that I grant permission for psychotherapy of the minor child/children.

Client Signature

Date

Client Signature

Date

Client Signature

Date

Therapist

Date