

Ceci Bolan, MS
Licensed Marriage and Family Therapist (# MFC 45251)
Compassionate Counseling Services
23201 Mill Creek Drive, Suite 220
Laguna Hills, CA 92653
949-678-9530

**OFFICE POLICIES & PROCEDURES/
INFORMED CONSENT**

1. Confidentiality: All information disclosed by me is confidential and may not be revealed by anyone without my written permission, EXCEPT where disclosure is required or permitted by law. Disclosure is generally required or permitted in the following circumstances: where there is knowledge or reasonable suspicion of child, elder, or dependent adult abuse or neglect; where I make a serious threat of physical violence towards a reasonably identifiable victim, or where I am likely to harm myself or someone else unless protective measures are taken. Before disclosing such information, my therapist will make all efforts to discuss her concerns with me first, if possible. However, my safety and the safety of others is always the foremost concern.

Initial_____

2. Emergencies/After Hours: If I am feeling unsafe and require immediate assistance, I agree to call 911 or go to the nearest emergency room. For non-urgent matters, I will call my therapist at **949-678-9530**, and leave a voicemail specifying my name, number where I can be reached, and reason for my call. My therapist will call me back as soon as possible, usually within 24 hours. While my therapist is on vacation, she will leave information on her voicemail as to whom to contact in her absence.

Initial_____

3. Counseling Sessions and Phone Consultations: Each counseling session is scheduled by appointment only and lasts between 45 to 50 minutes. If I need to have a phone consultation with my therapist, I will be billed at the rate of **\$25 per 15-minute increment**, AFTER the first 5 minutes.

Initial_____

4. Payment for Service: My therapist's fee for each session is \$_____. Payment for treatment is due at the BEGINNING of each session, and must be paid in full by either cash or check, made out to my therapist. **I will be charged a \$25 fee for any returned checks.** I understand that if I am more than one session payment behind in my payments, I will not be able to schedule another appointment until my account balance is paid in full. If I am unable to remain current with my payments, my therapist will give me three referrals to lower-cost therapists or agencies. I understand that, in some cases, unpaid treatment bills may be turned over to a collection agency.

Initial_____

5. Cancellation Policy: I understand that my therapist highly values both my time and her time. Because my scheduled appointment has been reserved specifically for me, I agree to give **at least 24-hours advance notice** if I need to cancel or re-schedule my appointment. Otherwise, I will be billed the full-session fee for the missed session, and will need to pay it in full at the beginning of my next session.

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6. Insurance: My therapist does not bill insurance companies directly. Therefore, I understand that I need to pay the full-session fee at the beginning of my appointment, and my therapist will provide me with a monthly invoice, at my request, which will serve as my receipt and proof of therapy services rendered. I will then be responsible for submitting claims for reimbursement to my insurance company.

Initial_____

7. Potential Risks and Benefits of the Counseling Process: I am aware that there are certain risks and benefits associated with the counseling process. Since therapy often involves discussing unpleasant aspects of my life, I may experience uncomfortable feelings that may present a need for psychiatric consultation in the event that my symptoms worsen, and/or during periods of severe anxiety, agitation, or depression. On the other hand, the counseling process may also have benefits for those who are committed to it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, I am aware that there are no guarantees of what I will experience.

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8. Termination of Services: I understand that I have the right to terminate treatment at any time, and for any reason. My therapist may also terminate treatment at her discretion. Reasons for termination may include, but are not limited to: untimely payment; failure to comply with treatment recommendations (such as not arranging for or following through on psychiatric medication evaluations, not keeping regularly-scheduled appointments, etc.); coming to session under the influence of drugs or alcohol; engaging in violent or threatening behavior on the premises; or if some problem emerges that is not within my therapist's scope of competence or practice.

Initial_____

I have read and understood these Office Policies & Procedures/Informed Consent, and have had any questions answered. I hereby authorize Ceci Bolan, MS, Licensed Marriage and Family Therapist (#45251) to provide me with counseling services. I also understand that I can discontinue treatment at any time.

Addendum

I have been informed that Ceci Bolan is **not employed by either the Center for New Directions or by Pilgrimage Family Therapy Center**; she operates as an Independent Contractor (dba "Compassionate Counseling Services"), and rents office space by agreement with the Center for New Directions.

Signature

Date

Printed Name