Melinda White, MA
Licensed Marriage and Family Therapist, MFT28729
ACT Certified Cognitive and Behavioral Therapist, #00111
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Treatment/Evaluation Agreement

This document contains important information about my professional services, confidentiality, and business policies. Please read it carefully and discuss any questions or concerns you have with me.

Assessment and Treatment

I will provide an assessment of your difficulties and available treatment options. If I recommend and you agree, I will provide cognitive behavioral therapy for you. CBT has been shown in controlled outcome studies to provide effective treatment for many problems and disorders. No guarantees can be made regarding the success of treatment, however. Treatment can be time-consuming and at times stressful. There is a small risk that your condition may worsen during treatment. Treatment can bring up many strong feelings. You and I will make treatment decisions collaboratively.

Training and Experience

I am a licensed Marriage and Family Therapist. I am trained to treat individuals, couples and families. I am qualified to diagnose and treat a wide variety of mental health issues, including but not limited to anxiety, depression, panic, OCD, ADHD, and social anxiety. I have been licensed by the state of California as an MFT since 1991. In addition, I have been certified as a founding fellow by The Academy of Cognitive Therapy.

The Client's Role

You are expected to play an active role in your treatment. This includes working with me to create treatment goals, completing symptom questionnaires, and monitoring your progress. You will be asked to complete homework assignments between sessions. If at any time, you are unhappy about the progress, process, or outcome of your treatment, please discuss this with me so we may attempt to resolve any difficulties and plan a treatment that better meets your needs.

Hours/Availability

I am available for psychotherapy sessions, Monday through Thursday. Sessions are typically 50 minutes long, once or sometimes twice per week initially. They may taper to twice a month during the final phase of therapy. Longer sessions for work with exposure and response prevention for OCD and panic are scheduled as needed. Though I will make every effort to respond to urgent client needs, I am not available on an emergency basis. Contacting your primary care physician, your local emergency room, or psychiatrist is recommended. We will determine during our initial evaluation if my level of availability is suitable for your treatment needs.

Confidentiality

Communications between you and me will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital/couples or family therapy, I will not disclose confidential information about your treatment unless all persons who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you**

know that I have a "no-secrets" policy when conducting family or marital/couples therapy. This means that if you participate in family or marital/couples therapy, I am permitted to use information obtained in an individual session when working with other members of your family. Please feel free to ask me about my "no secrets" policy and how it may apply to you.

There are exceptions to confidentiality. I am required by law to report instances of suspected child, dependent adult or elder abuse. I am required or permitted to break confidentiality when I have determined that a client presents a serious danger of physical violence to another person or when he or she is a danger to himself or herself. Another exception to confidentiality is if I am ordered by a court to release information as part of a legal proceeding.

Minors and Confidentiality

Communications between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. I will use my professional judgment as to what information related to your child's treatment is appropriate to share. Please discuss any questions or concerns you have about this topic with me.

Appointment Scheduling and Cancellation Policy

Sessions are typically scheduled once per week at the same time and day whenever possible. Your consistent attendance greatly contributes to a successful outcome. If you need to cancel or reschedule, I require 24 hours notice. If you do not provide 24 hours notice, you will be responsible for full payment for the missed session. Please be aware that insurance companies do not pay for missed or cancelled sessions.

Payment

Payment is due at the time of the session. I will provide a monthly statement that you can submit for insurance or other reimbursement plans. My fee for service is $225 per 50 minute session. For longer sessions, I prorate the charges accordingly.

Termination of Therapy

The length of your treatment depends on the progress you have made. I will discuss treatment goals and progress with you periodically throughout our treatment. I will help you plan for the termination of treatment as we are nearing that stage. You may discontinue treatment at any time. If you are dissatisfied with your therapy, I recommend that you discuss your concerns with me so I have an opportunity to offer recommendations, discuss possible consequences of ending treatment at that time and offer referral options if needed.

NOTICE TO CLIENTS 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.

Consent

Please sign below to indicate that you have read and understood this agreement for services and consent to its contents. Please ask me to address any questions or concerns that you have about this information before you sign. I have read and understood this agreement and have had my questions answered to my satisfaction and agree to abide by its terms and contents and consent to participate in evaluation and/or treatment.

Name of Client (please print) _____

Signature of Client/parent _____

Date_____