Hope for Healthy Families Counseling Center

8788 Elk Grove Blvd, Bldg 1, Suite L Elk Grove, California 95624
Phone (916) 686-9209 Fax (916) 667-3239

INFORMATION FOR CLIENTS

Confidentiality
Information revealed in the course of therapy is protected by professional and ethical standards. All material is confidential and not released without your written consent except information related to suspected child abuse, elder or dependent adult abuse, and situations involving imminent harm to oneself or others.

Informed Consent
The process of therapy requires courage, commitment, and risk taking. There may be times when the information discussed in a therapy session will cause distressing feelings and/or thoughts. At times, you may experience physical symptoms as a result of processing distressing information. Please share this with me, so we may explore together ways in which you can manage these feelings and thoughts. Because every person is different, there is no way to predict how you will respond to the process of therapy, or how long the process will take for you. Your therapy session is 50 minutes. If your session goes longer there may be an additional charge.

HIPAA
Under the Health Insurance Portability and Accountability Act of 1996, we are required to provide a Notice of Privacy Practices regarding your Protected Health Information (PHI). This is posted on the wall in the office.

Counselors
Your therapist is a MFT Trainee, MFT Intern, Professional Clinical Counselor Trainee, a Mental Health Practitioner, or a Psychological Student Trainee earning hours toward graduation or licensure and is under the clinical supervision of Executive Director, Leina Hoyt, Licensed Marriage and Family Therapist.

Fees and Payment
Your fee will be discussed with you prior to the first session. We request that you pay your fee at the time of each session, unless other arrangements have been made ahead of time. If your fee was established using a sliding scale, and your financial situation changes significantly during the course of treatment, your fee will be renegotiated. We accept cash, personal checks, cashier checks, major credit cards, and PayPal. Returned checks will incur a $25 fee. Please keep in mind that if your therapy is court-ordered, you may incur additional fees due to report writing, phone consultations, etc. Your fee is _____/session.

Cancellations
We have allocated your appointment time just for you. Cancellations or changes in session dates or times must be made 24-hours in advance. If an appointment is cancelled or missed without 24-hour notice, you will be charged for the session. For your convenience, we will charge your credit card below for any session that is not in compliance with our cancellation policy at the discretion of Hope for Healthy Families Counseling Center.

Your signature indicates that you have read and agree to abide by the above policies.

_______________________________________ ______________________________
Signature Date

Counselor's Initials ___________