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## **AGREEMENT FOR SERVICE / INFORMED CONSENT**

### **INTRODUCTION**

Welcome to my counseling practice! This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions or concerns that you may have so that we can discuss them prior to your signing it. When you sign this document, it will represent an agreement between us.

In this document, "Therapist" refers to Dani Graziano, MFT and "Client" refers to participants in counseling or any person using my professional services.

### **WHAT IS A MARRIAGE AND FAMILY THERAPIST?**

Marriage and Family Therapists (MFTs) are mental health professionals who bring a systems-oriented perspective to health care. We address a wide array of relationship issues, as well as evaluate and treat mental/emotional issues and other behavioral health problems. MFTs broaden the traditional mental health emphasis on the individual and attend to individuals in their primary relationship networks such as partner relationships and/or the family. MFTs take a holistic perspective to health care; we are concerned with the overall, long-term well-being of individuals *and* their families. MFTs are trained to assess, diagnose and treat individuals, couples, families, and groups.

### **RISKS AND BENEFITS OF COUNSELING**

Counseling is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for your sessions to be most successful, you will have to work on things we talk about both during our sessions and at home.

Counseling can have benefits and risks. Since counseling often involves discussing difficult aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, and frustration. On the other hand, counseling has also been shown to have benefits for people who go through it. Counseling often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress; but there are no guarantees of what you will experience.

Our first one to two sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer some first impressions of what our work will include and a treatment plan if you decide to continue. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I encourage you to meet with another mental health professional for a second opinion. After our initial evaluation, I may also refer you to another mental health professional if I feel that your presenting problem is outside of my scope of expertise.

## **MEETINGS**

I will usually schedule 50-minute sessions (one appointment hour of 50 minutes duration) per week or as needed at a time we agree on. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation.** \_\_\_\_\_ (initial)

## **CONTACTING ME**

I can be reached during normal business hours, Monday – Friday, 9 am – 5 pm, however I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail. I will make every effort to return your call by the end of the business day -- or within 24 hours if you call after 3:00 pm -- with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you have a counseling emergency, you may call the Access and Crisis Line at 1-800-479-3339, 24 hours a day/7 days a week. You should also contact your family physician and go to the nearest emergency room.

If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

## **PROFESSIONAL FEES**

Per 50 minute session (one appointment hour of 50 minutes), I charge \$100.00. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost by 15 minute increments if I work for periods of less than one hour. Other services may include report or letter writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, and preparation of records or treatment summaries. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

I reserve the right to periodically adjust my fee and will provide 1-month advance notification of any fee adjustment. *My fee may also be adjusted by contract with insurance or managed care organizations.*

## **BILLING AND PAYMENTS**

*Payment (fee-for-service) for services is due prior to the start of each session and rendered by cash, credit card or check unless we agree otherwise.* \_\_\_\_\_  
(Initial)

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. If such legal action is necessary, its costs will be included in the claim.

## **INSURANCE**

I currently do not accept any insurance. I will however, provide you with a super-

bill at the end of each month, which you can submit to your insurance company for reimbursement of fees. This super-bill may include information such as the type(s), cost(s), date(s), and providers of any services or treatments you receive.

Some insurance companies require pre-authorization of services and some services may not be covered by your insurance at all. Please check with your insurance company for information about covered mental health services. You are responsible directly to the therapist for all fees incurred for services provided.

### **PROFESSIONAL RECORDS AND CONFIDENTIALITY**

Please see my "Notice of Privacy Practices" for full disclosure of how medical information about you may be used.

### **CLIENT LITIGATION**

I will not voluntarily participate in any litigation or custody disputes. If I am subpoenaed, or ordered by a court of law, to appear as a witness in an action involving a Client, the Client agrees to reimburse Therapist for time spent for preparation, travel at my regular hourly rate of \$80/hour.

The information disclosed by you and any records created are subject to the psychotherapist-client privilege under the law, akin to the attorney-client or doctor-patient privilege. Typically the Client is the holder of the psychotherapist-patient privilege. If I am subpoenaed for records or deposition or court testimony, I will attempt to assert the privilege on Client's behalf until instructed in writing to do otherwise by Client or Client's representative.

You should be aware that you may be waiving psychotherapist-client privilege if you make your mental or emotional state an issue in a legal proceeding. You should address any concerns regarding the psychotherapist-client privilege with your attorney.

### **TERMINATION OF COUNSELING**

Therapist reserves the right to terminate counseling at her discretion, for reasons including but not limited to untimely fee payment, noncompliance with treatment recommendations, conflict of interest, failure to participate in counseling, or Client needs being outside Therapist's scope of practice or competence. Client also has the right to terminate counseling at his/her discretion. Upon either party's decision to terminate, Therapist will usually recommend Client 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.

**Your signature below indicates that you have read the information in the AGREEMENT FOR SERVICE / INFORMED CONSENT and NOTICE OF PRIVACY**

**PRACTICES DOCUMENTS, received a copy of both, and agree to abide by their terms in seeking counseling services with Therapist.**

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Person claiming financial responsibility for services:

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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