

Sharmaine D. Barnes, LMFT, CCTP, CEAP

2431 W March Lane ♦ Suite 200 ♦ Stockton, CA 95207-8211

Tel: (209) 475-8428 ♦ Fax: (209) 475-8479

Email: admin@sharmainedbarneslmft.com ♦ Web: www.sharmainedbarneslmft.com

INFORMED CONSENT AND AUTHORIZATION FOR PSYCHOTHERAPY

In addition to being a clinical process, therapy involves a professional arrangement regulated by laws, ethics, your rights as a client, and my standard business practices.

This document contains important information to help you make an informed decision about receiving services from Sharmaine D. Barnes, LMFT. Please read this document carefully because your signature on the last page of this document indicates that you have read the information in this document and agree to the business practices described herein.

ABOUT ME

My name is **Sharmaine D. Barnes** and I am a Licensed Marriage and Family Therapist in the State of California (#80569) and possess a Master of Arts Degree in Marital and Family Therapy with a specialization in African American Family Studies. I have worked in the mental health field in various capacities for the past 12 yrs and have a wealth of knowledge and experience working with individuals and families from diverse racial, ethnic, and socioeconomic backgrounds.

As a Licensed Marriage and Family Therapist (LMFT), I am a relationship specialist who treats persons involved in interpersonal relationships. I am trained to assess, diagnose and treat individuals, couples, families and groups to achieve more adequate, satisfying and productive marriage, family and social adjustment. I generally lean towards cognitive behavioral and solution-focused therapeutic approaches; however, I also employ other therapeutic approaches.

As therapist of Christian faith, I believe that prayer and scripture reading can be very beneficial to the therapeutic process and have no problem incorporating scripture reading and prayer in our sessions at your request.

INITIAL CONSULTATION(S) /ASSESSMENT(S)

The purpose of initial assessment(s) and/or consultation(s) is to determine your needs and to help you decide which services and/or form(s) of treatment may be desirable. Should you choose to proceed, a positive outcome then becomes our mutual responsibility. This begins with your trust in, and commitment to, the treatment process and my commitment to address your questions and concerns as they come up during treatment. It also involves my commitment to helping you develop balance in your thoughts, feelings, behaviors, and values.

RISKS/BENEFITS ASSOCIATED WITH PSYCHOTHERAPY

Psychotherapy is a process. No quick fix is available; therefore, expectations should not be too high. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

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Although therapy begins with the hope that your life and relationships improve, there is no guarantee that this will occur. Like many things in life, psychotherapy has inherent risks. Some of these possible risks to you include, but are not limited to, experiencing:

- Disruptions in your daily life that can occur because of therapeutic changes
- Emotional pain due to exploring personal issues and/or family history
- Emotional pain within your current relationships

On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But again, there are no guarantees of what you will experience.

**Your initials here acknowledging the above section:
Risks Associated with Psychotherapy: _____**

SESSIONS

I normally conduct an assessment/evaluation that may last from 1 to 2 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-minute session per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation.

**Your initials here acknowledging the above section:
Sessions: _____**

PAYMENT OF FEES

California law requires that all fees are established and agreed upon before we can begin. Paying for therapy is often a very sensitive topic. We can discuss any concerns you may have about payment prior to commencement of treatment and may revisit payment concerns throughout treatment as needed.

My standard fees are as follows: \$100.00 per forty-five (45) minutes for Individual Psychotherapy; \$150.00 per sixty (60) minutes for Pre-marital, Marriage or Couples Therapy; \$200.00 per ninety (90) minutes for Family Therapy. You agree to accept full responsibility for payment of all agreed-upon fees, which are due at the time of each appointment.

If you plan to bill your insurance company, please call your insurance company before we begin to determine the extent of your coverage for mental health services. You may also be responsible for any and all subsequent interactions with your insurance carrier. A superbill (receipt for fees paid, suitable for submission to your insurance company), will be provided at

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your request. If I am an approved provider with your insurance company, I will discuss with you your billing options. I make no guarantee whatsoever that your insurance company will reimburse you for these expenses. This section clarifies all fees and defines your financial responsibilities:

- My standard fees are \$100.00 per forty-five (45) minutes for Individual Psychotherapy; \$150.00 per sixty (60) minutes for Pre-marital, Marriage or Couples Therapy; \$200.00 per ninety (90) minutes for Family Therapy and are payable each session and beginning at your first appointment. Cash, Checks, Visa, MasterCard, Discover, American Express, and PayPal are accepted for payment. A \$35.00 returned-check fee will be assessed.
- Sessions are typically scheduled to occur one time per week at the same time and day, if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome.
- Canceling or rescheduling appointments requires a twenty-four- (24) hour notice by telephone at (209) 475-8428 to avoid having to pay the full fee for a missed session.
- Written communication and reports of any type are billed to you at the rate of \$2.00 per minute; therefore, if a report takes me sixty (60) minutes, you will be billed \$120.00. *These services are generally not covered by insurance.*
- Telephone calls between us lasting over 5 minutes are billed to you at the rate of \$2.00 per minute. For example, if I spend eleven (11) minutes speaking with you on the telephone, you will be billed \$12.00 as you are being charged for the additional six (6) minutes. *These services are generally not covered by insurance.*
- Authorized telephone communication(s)/consultation(s) with anyone concerning your therapy will be billed to you at the rate of \$2.00 per minute; therefore, if I spend twenty-five (25) minutes speaking to your attorney, you will be billed \$50.00. *These services are generally not covered by insurance.*
- Appearing at meetings or legal proceedings on your behalf is not covered by insurance and is billable to you at the rate of \$2.00 per minute for the entire time spent away from my office, including travel. For instance, if I am away from the office for eight (8) hours on your behalf, you will be billed \$960.00.
- 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. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

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Your initials here agree to the above section:
Payment of Fees: _____

LIMITATIONS & EXCEPTIONS TO CONFIDENTIALITY

- Normally, everything we discuss will be held confidential. Unless you provide a signed authorization, I will not speak to, or correspond with, anyone about you.
- If you choose to break confidentiality in any way (e.g., sending me an e-mail, applying for insurance reimbursement, telling anyone about your therapy, using an analog cell-phone), I cannot control, or be held liable, for the outcome.
- California laws and professional ethics, including standards of practice, either mandate, or permit, therapists to break client confidentiality under certain circumstances. Some exceptions to confidentiality include situations in which there is reasonable suspicion that any of the following has ever occurred or is occurring now: *(Note that the following is a sample, and not a complete list of exceptions to confidentiality.)*
 1. You present a danger to self or others
 2. A child (anyone under 18 years-old), dependent adult (anyone 18 years-old to 64 years-old who is dependent on others for their care), or elder (anyone over the age of 65 years-old) is, or was, the victim of emotional, sexual, or physical abuse or neglect (including abandonment, forced isolation, fiduciary abuse)
- Communications between therapists and patients 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. Consequently, I will exercise my professional judgment in discussing the treatment progress of a minor patient with the parent or caretaker.

Your initials here agreeing to the above section:
Confidentiality Limits & Exceptions: _____

MEDICAL, PSYCHIATRIC & PSYCHOLOGICAL EVALUATIONS

- If medical, psychiatric, and/or psychological evaluation seems appropriate, we will discuss the nature of these evaluations and appropriate referrals will be provided. If the need for evaluation(s) by other professionals is established and you do not follow these recommendations, your therapy may necessarily be suspended or terminated.
- Certain medications are sometimes prescribed before and/or during the course of treatment. If you are already taking prescribed medications when therapy begins or you begin medication during the course of this therapy, your medication compliance may be a condition of treatment.

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**Your initials here agreeing to the above section:
Medical, Psychiatric & Psychological Evaluations: _____**

LIMITS OF COMMUNICATION

- I am often not immediately available by telephone. While I am usually in my office between 10 AM and 7 PM, I will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by confidential voice mail that I monitor frequently. I will make every effort to return your call within 24 hours of the date I receive it, with the exception of weekends and holidays.
- Every effort will be made to assist you, especially during crisis. However, there may be times when contacting you won't be possible. Therefore, you must agree to *first* call 911 or go to the nearest hospital emergency room for assistance at any time you suspect that you are in crisis.
- As a standard business practice, each appointment ends forty-five (45) minutes from the scheduled start of the appointment, regardless of your arrival time. I am not able to extend sessions except in the case of a clinical emergency (e.g., client hospitalization needed).
- If I anticipate being unavailable for an extended period of time (e.g., on vacation, out of town), my voicemail will provide the name and telephone number of a colleague who you can call for assistance when I am not available.
- E-mail, fax, and web-based communications are not confidential methods of communicating. *Please keep this in mind when contacting me via these modes of communication or when requesting that I contact you or someone regarding your case.*
- I maintain very firm professional boundaries with my clients; therefore, I do not accept personal communication of any nature, in any capacity (e.g., attempts to "friend" a personal Facebook presence, etc.). I reserve the right to terminate treatment if, for any reason, a client obtains my home telephone number or my residential address or makes attempts to connect with me in any other way on a personal level.

**Your initials here agreeing to the above section:
Limits of Communications: _____**

TREATMENT TERMINATION

If at any time during the course of your treatment I determine I cannot continue, I will terminate treatment and explain why this is necessary. Ideally, therapy ends when we agree your treatment goals have been achieved. Additional conditions of termination include:

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- You have the right to stop treatment at any time. If you make this choice, referrals to other therapists can be provided and you will be asked to attend a final 'termination' session.
- Professional ethics mandate that treatment continues only if it is reasonably clear you are receiving benefit.
- Legal or ethical circumstances may arise which may compel me to terminate treatment. In these cases, appropriate referrals will be offered. Also, I do not diagnose, treat, or advise on problems outside the recognized boundaries of my competencies or scope of practice.
- Other situations that warrant termination include, but are not limited to multiple late cancellations, not showing up for scheduled appointments, becoming enraged or threatening during session, bringing a weapon or illicit drug onto the premises, persistent drug abuse, arriving under the influence of drugs or alcohol, or disclosing illegal intentions or actions.

Your initials here agreeing with the above section:
Treatment Termination: _____

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. There is a .25 per page copying fee.

Your initials here agreeing with the above section:
Professional Records: _____

ARBITRATION

You agree to submit any disagreement concerning services or complaints regarding breaches in law or ethics to binding arbitration under the auspices of the American Arbitration Association. You agree to pay any and all legal costs arising from complaints that are not fully validated by you, the arbitrator. You also agree to pay any other legal fees incurred by Sharmaine D. Barnes, LMFT as a result of these sessions.

Your initials here acknowledging the above section:
Arbitration: _____

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OFFICE ENVIRONMENT

- Please turn your cell phone volume off, or to silent mode, and do not talk on cell phones in any part of the office. If you need to take/make a call while on premises, please step outside, closing the door completely behind you.
- Inappropriate language (e.g., swearing, yelling) will not be tolerated in the office.
- Appropriate dress is required (e.g., no: swimsuits, bare midriffs).
- Please respect the confidentiality of others in the public areas of the office. It is inappropriate to ask others to share any personal information including, but not limited to: client/patient name, which professional they are here to see, and/or reason for their visit.

**Your initials here acknowledging the above section:
Office Environment: _____**

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client Signature

Date

Sharmaine D. Barnes, LMFT, CCTP, CEAP

Date