W I N N I E P I C C O L O M. A. M F T

Individual, Couple and Group Psychotherapy
License No. MFC24602

825 College Ave, Santa Rosa, Ca. 95404
(707) 578-0426 ext. 1 wpiccolo@sonic.net

OFFICE POLICIES / AGREEMENT FOR SERVICE / INFORMED CONSENT

INTRODUCTION: This agreement is intended to provide you, the psychotherapy client, with important information regarding the practices, policies and procedures of Winnie Piccolo MA MFT, and to clarify the terms of the professional therapeutic relationship between therapist and client. Any questions or concerns regarding the contents of this agreement should be discussed with me prior to signing it and may of course be raised at any time thereafter.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed by me to anyone without your written permission except where disclosure is required by law.

WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW: Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or becomes gravely disabled. Disclosure may also be required pursuant to a legal proceeding by or against you (if I am subpoenaed). If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by the therapist.

HEALTH INSURANCE
I choose not to be on insurance panels but will submit statements to PPO insurance plans if you have out-of network coverage. It is your responsibility to verify and understand the limits of your coverage, as well as your co-payments and deductibles.

PATIENT LITIGATION: Please be aware that I will not voluntarily participate in any litigation or custody dispute in which a client (past or present) in my practice is a party. I have a policy of not communicating with a client's attorney(s) and will generally not write or sign letters, reports, declarations, or affidavits to be used in a client's legal matter. I will generally not provide records or testimony unless compelled to do so

PROFESSIONAL CONSULTATION: Professional consultation is an important component of a healthy psychotherapy practice. I consult as needed with other professionals regarding my work with my clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained.

E–MAIL: It is very important to be aware that computers and email communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails are vulnerable to unauthorized access due to the fact that Internet servers have unlimited and direct access to all emails that go through them. It is important that you be aware that emails are part of the medical records. If you communicate confidential or private information via email, I will assume that you have made an informed decision and will view it as your agreement to take the risk that such communication may be intercepted. When you email me, I will always keep my responses brief and to the point. I do not view email as an effective substitute for face-to-face therapy.

TELEPHONE AND EMERGENCY PROCEDURES: If you need to contact me between sessions, please leave me a message at 707-578-0426, ext 1. I will return your

call as soon as possible. I check my messages regularly in the daytime, less often on weekends. If an emergency situation arises, indicate so clearly in your message. You have the option of calling my number and pressing 0 for an operator who will assist you in locating me. If for some reason I cannot be located you may be referred to Psychiatric Emergency Services. Sending me an email as well could increase the chance of contacting me successfully. You also have the option of calling Psychiatric Emergency Services yourself at 707-576-8181.

FEE ARRANGEMENT AND CANCELLATION POLICY: My current fee is $130 per (60 minute) hour. You are expected to pay at the time of your appointment, unless another arrangement is made with me. You are responsible for payment of the agreed upon fee for any session for which you have not given at least 24 hours notice of cancellation. It is my experience over many years that late cancellations generally involve legitimate and serious reasons, such as sudden illness. My cancellation policy is a necessary and objective business practice, not meant to be a punitive measure. I sincerely regret that sometimes this policy can feel upsetting or unfair. It is important to discuss any reactions that arise in your next session with me.

ACKNOWLEDGMENT: By signing below, you acknowledge that you have reviewed and fully understand the terms and conditions of this agreement

_____

Client Name (please print)

_____ _____

Client Signature Date