**Matilde A. Konigsberg, LMFT**

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# Agreement for Professional Psychotherapy Services

Dear Client,

The following are my office policies and procedures and they have been designed to provide the best possible care that I can offer as you have made the important decision to begin psychotherapy. In my professional experience, consistency and continuity are two very important elements in the process of a successful therapeutic outcome.

The goal of this agreement is to provide a clear understanding between client and therapist and to establish a positive relationship for counseling. I look forward to working with you.

1. Individual therapy sessions are normally scheduled on a weekly basis. Each session consists of 55 minutes. **My fee per session is $168.00.00 unless otherwise negotiated on an individual basis. My fee for coaching, mediation and/or co-parenting intervention is $180.00 per hour**. To get the full value of your session, please follow my recommendations and assignments.
2. The hour for your therapy appointment is reserved strictly for you. If you cannot make the appointment, **please call to cancel 48 hours in advance** or the full charge will be made for whatever time allotment your appointment was. **There will be no exceptions to this policy.** If you are late for your appointment, you will be charged for the full appointment unless I am notified. I generally consider more than 20 minutes late to be a cancelled appointment. To notify me about a late appointment, please reach me directly on my cell phone at (415) 302- 1655.
3. Insurance companies **will not pay** for canceled appointments so you are responsible to pay for any missed appointments at my **full/regular fee**.
4. Payments and co-payments are charged automatic through **Therapy Partner**. You will receive an automated generated invoice via e-mail once a month.
5. There is a service charge of $25.00 for any returned checks.
6. If arrangements to bill your insurance company are made at your first appointment, I require that your estimate share or deductible be paid at the time of your visit. If your insurance carrier does not remit payment within 90 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance I estimated, I will promptly refund the credit amount to you.
7. There are no charges for phone calls to change appointments. Short conversations will be accepted when I am available, extended phone conversation (more than 5 minutes) or crisis phone calls will be billed at the same rate as individual therapy sessions. Calls to other professionals in reference to your case, will be charged for in quarter hour segments.
8. I request that you remain in the waiting area until your appointment time. If I am more than 10 minutes late, please knock on my door. **Please have your cell phone turned off before beginning your session**.
9. Please notify me within 30 days of any change in address, telephone number, and any changes in your financial information as well.
10. The therapist reserves the right to terminate therapy at her discretion. Reasons for termination include, but are not limited to: Untimely payment of fees, failure to comply with treatment recommendations, conflicts of interests, failure to participate in therapy, the client’s needs are outside of the therapist’s scope of competence, or the client is not making adequate progress in therapy. The client has the right to terminate therapy at his/her discretion. Upon either person’s decision to terminate therapy, the therapist will generally recommend that the client participate in at least one or more termination sessions. The therapist will also attempt to ensure a smooth transition to another therapist by offering referrals.

# Confidentiality Agreement

1. I am legally and ethically bound to maintain the highest degree of confidentiality. However, there are certain circumstances under which **I am required by Oregon law** to disclose information. The limits of confidentiality involve cases in which I must report to the proper authorities (and/or the intended victim) any serious threat of harm to yourself, another person, or to property. In cases of suspected child or elder abuse, I am legally bound to make a confidential report to the authorities. If such a report is deemed appropriate, it will be carried out in a professional manner.

You should also be aware that your confidentiality can be waived if you tender your mental condition in a civil or criminal litigation. This situation needs to be discussed with your attorney.

# HIPPA Privacy Regulations (Adopted 4/14/03)

Per regulations adopted by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), patients are required to be informed of procedures for the protections of their patient information. Patients are also required to sign this form indicating that these procedures have been explained, and that they authorize therapy to begin:

1. Patient records will be kept in a locked file and confidentiality will be strictly maintained.
2. Patient information will be provided to third parties only with the signed consent of the patient.
3. HIPPA policy statements in no way alter current State requirements regarding confidentiality, or disclosure of information in cases of “risk of harm to self or others” or matters of suspected child or dependent adult abuse.

**I have read the foregoing and understand what it says. To the extent that I have any questions, I have asked them of my therapist before signing this consent. I have also read and received a copy of the Professional Disclosure Statement provided by Matilde Konigsberg, MFT**

Client’s signature Date

Client’s signature Date

PARENTAL/GUARDIAN CONSENT:

I consent that my son/daughter participates in therapy sessions. Parent/Guardian signature Date

# CLIENT INFORMATION

## Name of client (s) DOB Age

 DOB Age

 DOB Age Address

Phone numbers: Home

E-Mail

Work

Cell Fax

Referral Source Marital Status

Occupation (former, if retired)

Person and phone number to call in an emergency Any medical issues of concern?

Have you been in any type of lawsuits? Cultural, ethnic, religious background Previous treating therapist (if any):

Name Phone number

Briefly describe the outcome of previous treatment:

Any history of mental illness, drugs/alcohol abuse or suicide thoughts or attempts for yourself or your family?

Briefly describe the presenting problem (be as specific as you can: when did it start, how does it affect your life:

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 Estimate the severity of the problem:

Mild , Moderate , Severe , Very severe .