ELIZABETH L. RAMIREZ (MFT45179)
Marriage & Family Therapist
DISCLOSURE STATEMENT

This document contains information about my professional services and business policies. Please read this information carefully and ask any questions at any time. I assume that my clients are responsible, autonomous, functioning, and not in need of day-to-day supervision. Clients are expected to discuss any expectations of after-hours care upon intake so that an appropriate referral can be made if necessary.

About Treatment: Benefits, Risks, and Alternatives

The majority of individuals who obtain psychotherapy report that they benefit from the process. Success may vary depending on the particular problems being addressed as well as the level of client involvement. Treatment, no matter how effective, cannot guarantee complete recovery. Self-exploration, gaining understanding, finding new ways for dealing with problems, and learning new skills are generally quite useful, however, some unexpected changes may occur.

While the benefits of psychotherapy are well known, you may experience difficult feelings during the treatment. These are a natural part of the healing process and often provide the basis for change. Important personal decisions are often a result of therapy such as behavior and relationship changes or employment. These are likely to produce new opportunities as well as new challenges.

Openness, honesty, and willingness assist in a positive outcome. You may benefit from therapy when you participate fully. In signing this disclosure, you are agreeing to a "*No Secrets Policy*" between members of a treatment unit. When I see non-patients as part of the client treatment, that person(s) should not have an expectation of confidentiality. I would, however, have to assert privilege. In addition, the non-client has the right to privacy.

I use a relationship-focused approach including solutions outcomes and skill building. Treatment is planned with agreed upon goals after a thorough assessment. It may take up to three sessions to mutually decide on the treatment. There are other treatment approaches that I will discuss upon request. If needed, I will refer you to three other therapists to continue your counseling process.

Contacting Me

My office schedule is generally Monday through Thursday, 9am to 6pm. I am unavailable for appointments on Fridays and weekends. Calls received on Fridays will be returned on the following Monday. You can leave a voicemail, text message and email message. Phone number: 831-754-3077, elramirezmft@gmail.com.

Emergencies

In a ***psychological emergency*** call 911 or go to the nearest hospital emergency room including: Natividad Crisis Team 755-4111 or Community Crisis Line 625-4623.

When I am out of town or close the office for an extended time, we will prepare for the gap in sessions or another mental health professional may cover my practice. We will develop a plan that meets your needs.

Email Communication

Email is not a secure form of communication. If you want to communicate by email, I prefer to limit this format to appointment scheduling issues. Please discuss therapy issues in person or by phone to protect your privacy.

Confidentiality

Information disclosed within psychotherapy sessions is generally confidential and no information will be released without your written permission. However, I do respond to subpoenas as required by law or when an applicable legal or ethical exception exists. I am a treating psychotherapist and do not provide services in contemplation of legal proceedings nor psychological evaluations. However, if I do respond to a subpoena, I bill according to a total of all time and costs related to responding. Questions regarding legal issues should be discussed with your attorney.

I am legally required to report any suspected child, elder, or dependant adult abuse and any situation where the client threatens violence to an identifiable victim. The law also permits me to break confidentially when the client presents a danger to self unless protective measures are taken.

Place your initials alongside the preferred communication methods:

Phone calls	_____	Text Messages	____
E-mail Messages	_____	Fax	____
Post Mail	_____		

Treatment of Minors as Individual Clients

I prefer treating minors with the signed consent of both parents who have legal custody. I will make the effort to contact both parents to provide the best treatment. In the case of a divorce or separation, I request a copy of the current custody order and any other related documents.

I maintain a child's privacy during their counseling process. Children are at liberty to share their counseling experience to anyone of their choosing. When I deem it necessary, I may discuss with the child the importance of sharing information with their parents.

I collaborate with the parents with the best interest of the child as the focus. I request parents participate as needed during the child's treatment. This could include conversations to update on the child's counseling process, parenting sessions or family sessions. We will discuss the plan as the appropriate therapy treatment is developed.

Fees and Billing

Fees are collected at each session. My fee depends on each client. The options vary based on use of insurance plans, another service or paying the cost yourself. I may make different fee arrangements with clients on a case-by-case basis. Telephone calls over 15 minutes will be prorated at the session rate. My typical cost is $120.00 per session. .

Your cost for sessions: _____

Total cost for each session: _____

Appointments cancelled with less than **48-hour notice** will be charged a **missed appointment fee** equal to the total cost of a session.

Insurance Coverage and Copayments

You are responsible for obtaining any necessary ***prior authorization*** for treatment from your insurance carrier or EAP plan. EAP services generally offer minimal amounts of sessions. Further sessions may be available through your insurance plan. I will bill your insurance/EAP, however, you are responsible for copayment amounts and deductibles as set by your benefit plan. ***Missed appointments*** are not covered by insurance plans and the charges associated with them are your responsibility.

You are responsible for 100% of the bill. At any time during treatement should your eligibility or coverage for insurance or EAP change, please notify me as soon as possible.

Consent to Exchange Your Information

I will coordinate care with your treating physician or other providers to facilitate your treatment if you request this collaboration.

Finalize Treatment

You have the right to end your counseling work with me at any time. I ask that you meet with me at least once before discontinuing psychotherapy to discuss the process. If it does not appear to me that you are benefiting from your work with me or if your problem is outside my scope of expertise, I may refer you to alternative professional services that may better meet your needs after a discussing this plan with you.

Treatment may also be terminated if the conditions of treatment are not met. For example, failure to obtain a recommended psychiatric or medical consultation, arriving to sessions under the influence of substances/alcohol, unwilling to achieve mutually agreed upon treatment goals, frequent cancellations, missed appointments or failure to pay.

Acknowledgement

I have been informed and hereby acknowledge that Elizabeth Ramirez, MFT is a psychotherapist in private practice.

I have reviewed this disclosure and have had my questions answered to my satisfaction. I understand and agree to abide by its contents and I wish to participate in treatment/evaluation. I have received a copy of this disclosure.

_____

Client Signature (Parent if minor) Date

Insurance Authorizations

I authorize my insurance/EAP plan to directly pay Elizabeth L. Ramírez, MFT.

_____

Client Signature (Parent if minor) Date

I authorize Elizabeth L. Ramírez to make any contact necessary with my insurance/EAP plan in order to facilitate payment.

_____

Client Signature (Parent if minor) Date

I have discussed the issues herein with the client. My observations of this person's behavior and responses give me reason to believe that he or she is competent to give informed and willing consent to treatment.

_____

Signature of **Therapist** Date