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Lic. MFT 42383

Informed Consent for Treatment

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

SERVICE PROVIDER:
Yuko Brull, MFT
Licensed Marriage and Family Therapist

EDUCATION/DEGREES/TRAINING:

- Masters in Clinical Psychology, 2000
  Antioch University Los Angeles
- Bachelor of Arts in Sociology and Anthropology, 1995
  Sophia University, Tokyo Japan
- Bachelor of Arts in Sociology and Anthropology, 1995
  Sophia University, Tokyo Japan
- Youth Mindfulness Curriculum Training, Mindfulness School Online, 2014
- Cognitive Behavioral Therapy Certification Program, 2015
- Post Graduate Internship, completed 2004
  Caring for Children and Families with AIDS, Culver City, CA
- Positive Action Counseling Center, Inglewood, 2004
- Intercommunity Guidance Counseling Center, Whittier, CA, 2003
- MFT Trainee, Completed 2002
  Antioch University Counseling Center, Marina Del Rey

REGISTRATION:
Licensed Marriage and Family Therapist
California Board of Behavioral Sciences
License # 42383

MENTAL HEALTH SERVICES
I am a licensed Marriage and Family Therapist in the state of California. I provide individual and family therapy. Areas of specialization include: anxiety, depression and life transitions and adjustment issues. Therapy is not easily described in general statements. It varies depending on the personalities of the Marriage and Family Therapist and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. You are entitled to receive information regarding your treatment plan, such as methods of therapy, the techniques used, and duration (if known).

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

Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of life, you or your child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy 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 there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of you or your child's needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you or your child feels comfortable working with me. Therapy involves a commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion. You, or your child, have the right to terminate therapy at any time although I recommend doing so only after discussing your concerns with me directly.

A decision on my part for early or premature termination of our professional relationship would be for one of the following reasons: it is reasonably clear that you or your child no longer need, are not benefitting from, or are being harmed by treatment, or if you or someone in a relationship with you threatens or endangers me, if you are in need of services that I am not able to provide, financial non-cooperation, or any other needs of mine. Should we prematurely end our professional relationship, you or your child will be provided with appropriate referrals and recommendations about how to proceed unless your actions make it impossible, such as refusing to attend therapy sessions.

MEETINGS AND CANCELLATION

I normally conduct an evaluation that will last from one to four sessions. During this time, we can decide together if I am the best person to provide the services you or your child need in order to meet your treatment goals. If therapy is begun, I will usually schedule one 50-minute session per week at a time we agree on, although some sessions may be longer or more frequent. Scheduling an appointment involves the reservation of time specifically for you or your child. Once an appointment hour is scheduled, you will be expected to pay the standard fee for it unless you provide 24 hours advance notice of cancellation, unless we both agree that you were unable to attend due to circumstances beyond your control. If you are late for a session, I am not required to extend the appointment to make up for lost time, and if you have not called ahead, I may not wait more than 25 minutes.

I understand that I must cancel sessions 24 hours in advance or I may be billed for the scheduled hours.

______________________ *initial(s)*

PROFESSIONAL FEES

My 50-minute clinical hour fee for face-to-face or phone sessions is $150. Ninety-minute sessions are $270. In addition to weekly appointments, I charge this amount for other professional services you or your child may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you leave more than 10 minutes worth of phone messages in a week, or if I spend more than 10 minutes reading and responding to emails from you during a given week, I will bill you on a prorated basis for that time. Therapeutic sessions lasting over 50-minutes in length for couples, family sessions, or other reasons, may be subject to additional service fees. My fees go up $10.00 every two years, on the even year. If a fee raise is approaching I will remind you of this well in advance.

I understand that therapy and all related services are billed at $150 per clinical hour, $270 per 90 minutes and additional time is billed at a prorated rate.

______________________ *initial(s)*

In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment.

If you are currently receiving a rate reduction that has been previously arranged, please enter this rate here: _______ and initial below.

I understand that therapy is billed at a reduced rate of $_____ per clinical hour.

______________________ *initial(s)*

If you or your child becomes involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $320 per hour for preparation and attendance at any legal proceeding.

____________________ *initial(s)*

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. Payment schedules for other professional services will be agreed to when they are requested. Fees are collected at the each visit for the hours performed that day. **Having your cash or check ready at the beginning of each session is easier and avoids wasting therapy time.**

There will be a returned check fee of $25.00 should there be any problems clearing your check. If for any reason you do not pay your bill at the time of service, a $50.00 late fee will be assessed for each 30 days that you do not pay. 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 client's treatment is his/her name, the nature of services provided, and the amount due.

Payment must be made in the form of cash or check. Please make all checks out to: **Thrive OC**

I understand that I must pay at the time of each visit.

____________________*initial(s)*

INSURANCE

This practice does not accept medical or mental health insurance and will not bill your services directly to your insurance carrier. If you have a health insurance policy, however, it will usually provide some coverage for mental health treatment. I will provide you with whatever assistance I can in helping you receive reimbursement for the services you have paid for, such as providing insurance ready statements at the end of each month detailing any direct payments you have made to the practice. These statements can be used to initiate the reimbursement process privately through your insurance company if you choose. You (not your insurance company) are responsible for full payment of my fees, as outlined above. It is very important that you find out exactly what mental health services your insurance policy covers if you wish to submit a claim for reimbursement. Authorization is usually required in advance. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator.

Please note that insurance companies usually require the therapist to identify a diagnosis, and there are some diagnoses for which they will not reimburse. Whatever information is disclosed to your insurance company will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

I understand that my insurance cannot be billed directly for services provided by Yuko Brull. I am responsible for full payment.

____________________*initial(s)*

CONTACTING ME

General contact procedures: I am often not immediately available by telephone. I will check messages several times during the week, but may not do so daily. When I am unavailable, my telephone is answered by voice mail. If you are difficult to reach, please inform me of some times when you will be available. In most cases I will return your call within 24 hours with the exception of holidays. However, I cannot guarantee a phone response within a certain period of time. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Emergencies: Please be aware that **I do not provide emergency services** or wear a pager and am not "on call." If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician, 911, or the nearest emergency room and ask for the Marriage and Family Therapist or psychiatrist on call.

I understand that Yuko Brull does not provide emergency services. In an emergency situation, I know to call 911 or go to the nearest hospital emergency room.

______________________*initial(s)*

PROFESSIONAL RECORDS

You have specific rights with regard to your clinical record. Your file will remain active while you are participating in treatment. *When our work concludes, or it has been at least 30 days since our last contact, your file will be closed.* You may request amendments to your record, request to restrict the information disclosed to others, request an accounting of disclosures, and determine the location to which protected health information is sent (please see my Notice of Privacy Practices for more information). The laws and standards of my profession require that I keep treatment records. Except in specific circumstances, you are entitled to examine your or your child's clinical record and/or receive a copy at a rate of ¢25 per page. If you wish to see you or your child's records, you must request to do so in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. In the event that you do review the full records I recommend that they are reviewed in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests. You may request that any complaints you have about my privacy policies and procedures be recorded in your records.

I understand my rights pertaining to my clinical records, and that my file will be closed at the conclusion of our work together or 30 days after our last contact.

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CONFIDENTIALITY

In general, the privacy of all communications between a client and a Marriage and Family Therapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your case. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I suspect or believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include, among others, notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you or your child may have at our next meeting. I will be happy to discuss these issues with you or your child if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. Please see my Notice of Privacy Practices for more detailed information regarding confidentiality.

You or your child is also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you or your child electronically (for example, faxing information), it will be done with special safeguards to insure confidentiality.

If you or your child elects to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you or your child, and any responses that I send to you, will be printed out and kept in you or your child's treatment record.

I understand that my or my child's mental health information will be kept confidential unless my Marriage and Family Therapist believes that I, or my child, may harm myself, or his/her self, or someone else, if I disclose that a child, elderly person, or disabled person is being mistreated, if a judge orders it, or If disclosure is otherwise specifically required by federal, state, or local laws.

______________________*initial(s)*

COUPLES
This is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in couples therapy with me. If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. Do not tell me anything you wish kept secret from your partner. I will remind you of this policy before beginning such individual sessions.

MINORS
In regard to information disclosed by minors in session, it is important that they are able to trust the therapy process completely. Therefore, it is my policy to request an agreement from parents that they give up access to their child's records. Thus, such information will be kept confidential in the same way that confidentiality is maintained for an adult (please see the "Confidentiality" section above for details). As the parent or guardian, you have the right and responsibility to question and understand the nature of treatment and progress with your child. Ms. Brull will use clinical discretion as to what is appropriate to disclose.

Note to minors, if you are less than eighteen years of age please be aware that the law may provide your parents the right to examine your treatment records. If they agree to give up access to your records, I will provide them only with *general information* about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I may also offer a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

Parents are expected to bring their child to treatment personally (unless arranged in advance with Ms. Brull) and must stay in the waiting room or immediate area during the session. This enables parents to participate in treatment or help their child if it becomes necessary. Parents are also expected to be on hand to take a child to the rest room during session.

I understand that I am responsible for brining my child to each session and remaining on site and available during the therapy hour. I agree to give up access to my child's record and receive general information about treatment, unless there is an emergency, in which case I will be notified.

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PLEASE NOTE

Ms. Brull is an independent practitioner/contractor and *is not* formally associated with any group or other practitioner. Sharing office space, forms, or expenses with other clinicians does not imply any professional involvement with other practitioners, and they are not responsible in any way for actions Ms. Brull may take. Likewise, Ms. Brull is not responsible for any actions taken by colleagues sharing office space, forms or expenses.

Yuko Brull, LMFT - Clinical Marriage and Family Therapist
Email: YukoBrullMFT@gmail.com

26932 Oso Pkwy, Suite 200, Mission Viejo, CA 92691• Phone: (949) 293-2558

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

I have received and understood the above information. I have been given a copy of this form for my records, and I voluntarily consent to the agreed upon services. I agree to meet all financial obligations.

Signature of Client:

____

Printed Name: ____ Date: ____/____/ ____

Signature of Client:

____

Printed Name: ____ Date: ____/____/ ____

Signature of Personal Representative (if other than client):

____

Printed Name: ____ Date: ____/____/ ____

Signature of Personal Representative (if other than client):

____

Printed Name: ____ Date: ____/____/ ____

______________ ____________________________________

Date **Signature of Clinician as Witness**

NOTICE: The Board of Behavioral Sciences regulates the practice of: LMFT, LCSW, LPCC and LEP in the state of California. Concerns or complaints regarding the practice of therapy may be directed to the. Board of Behavioral Sciences. The contact information is: 1625 N. Market Blvd, Suite S200**,** Sacramento, CA 95834 www.bbs.ca.gov
Telephone Number: 1-916-574-7830