Shannon Lee, L.M.F.T.

OFFICE LOCATION
3111 Los Feliz Blvd Suite #106
Los Angeles, CA 90039
661-208-5099

OFFICE POLICY AND INFORMED CONSENT

Welcome: Welcome to my practice. I appreciate your interest and look forward to working with you to improve your life situation. Please read over the following Office Policy and Informed Consent and initial where indicated.

Provider: I am Shannon Lee, a licensed Marriage and Family Therapist (MFC# 47482). I am not a medical doctor nor am I a psychologist or a psychiatrist.

Therapist Communications:
There may be times when I want to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform me if you do not wish to be contacted at a particular time or place, or by a particular means. Please describe any specific information here:

_____

_____

_____ Initial My therapist may call me at my home.
My home phone number is: _____

_____ Initial My therapist may call me on my cell phone.
My cell phone number is: _____

_____ Initial My therapist may call me at work.
My work phone number is: _____

_____ Initial My therapist may send mail to me at my home address.
My home address is: _____

_____ Initial My therapist may communicate with me by email.
My email address is: _____

_____ Initial My therapist may send a fax to me.
My fax number is: _____

Appointments: Appointments are made directly with me and/or with my administrative staff. If you need to cancel an appointment, please let me/us know at least 24 hours in advance to prevent a charge for the missed session ($100.00 charge). Please understand that you will be charged for appointments cancelled with less than 24 hours notice or missed entirely without notice. You will be responsible for this fee as insurance companies will not cover the cost for missed appointments. As a courtesy I have reduced this fee from $200.00 to $100.00.
_____ Initial

Alcohol & Substance Intoxication: For psychotherapy to be most effective, clients must not be under the influence of any intoxicating substances, such as alcohol or other drugs. It may be necessary to reschedule your appointment in which case this will be considered a late cancellation and you will be charged the full fee.
_____ Initial

Session Time: Please understand that your insurance pays for a 45-50 minute session. This may vary from each insurance plan, although due to billing and code changes, the usual session time approved by most insurance companies appears to be fairly consistent across the board, being a 45-50 minute session, regardless of your insurance plan. Please note the length of each session time will be at the discretion of the therapist, being approximately 45-50 minutes. If you are late to your appointment, the 45-50 minute guideline still applies and the therapy session will not be extended. Please understand that your insurance pays for a 45-50 minute session only and any time over this is not reimbursed. Please be respectful of this guideline. If you feel you need more than a 45-50 minute session please discuss this with me before the session so we can discuss authorization of a longer session as needed and if applicable. If I am late to begin the therapy session I will extend the session to comply with the 45 minute session time.
_____ Initial

Phone Calls: Any phone call that exceeds fifteen minutes or more will be billed to you (as insurance does not cover this service) and you will be charged a $40.00 fee for a 16-30 minute phone call, increasing $40.00 for each additional 15 minute time frame.
1-15 minutes=no charge
16-30 minutes= $40.00 charge
31-45 minutes= $80.00 charge
46-60 minutes=$120.00 charge.
As a courtesy the first fifteen minutes of phone consultation is waived.
_____ Initial

Contact Instructions: You may leave a message for me at (661) 208-5099. I do my best to return phone calls in a timely manner. If I do not return your phone call within 24-48 hours you may call again and leave another message. Please note at times I may not be able to return your phone call within this time frame although I will do my best to do so. Also note I am in session typically from 9-5 Monday through Friday, although at times I am in session outside of these times, which may keep me from returning your call immediately.

_____ Initial

In an Emergency: If you need to reach me immediately, you can leave a message at the same number and please state that it is urgent. Please remember to leave all contact information, even if you believe that I already have it, because I may not have it readily available when I retrieve your message. I will return your call as soon as possible. If you are experiencing a life threatening emergency, please call 911 or go directly to a hospital emergency room. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance. You should also be aware of resources that are available in the local community to assist individuals who are in crisis. A complete list of these resources may be found at my website: www.therapistshannon.com
_____ Initial

Patient Care Summary: A patient care summary is an electronic health care record that contains your medical health information. By signing below you are giving me permission to access and receive a consolidated view, or history, of your past health care services and your medical history, which may assist me in improved delivery of health care. For example, if you can't remember the specifics about a service or procedure, this information may be available in the Patient Care Summary. Currently, a patient care summary exists for: Anthem, Blue Cross and Blue Shield of Georgia, and BLUE KC health insurance plans.
_____ Initial
Signature:_____

Payment for Services: Clients are expected to pay for services at the time they are rendered unless other arrangements have been made. Insurance companies will be billed as a courtesy to you but you are expected to pay any co-payments at the time of service. Please sign below to authorize payments from insurance companies to be sent directly to me.
Signature:_____
Insurance Company to be billed: _____

Therapist Fee Per Session and Copay:
I agree to pay a fee of $200 per therapy session. My co-payment portion is $_____. I understand that I am responsible for payment (100.00 charge) if I cancel a session without 24 hours notice or miss a session entirely without notice. Payment may be made by **cash only** for payment and copay.
_____ Initial

Process of Treatment/Evaluation: Participation in treatment can result in a number of benefits for you. Working toward these benefits can be difficult (although it doesn't always have to be) and requires effort on your part. Psychotherapy requires active participation and openness to change your thoughts, feelings and/ or behaviors. I will ask for feedback on your views on your therapy and its progress. During treatment/ evaluation, discussing some events, feelings or thoughts can result in considerable discomfort or strong feelings such as anger, sadness or worry.

Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes another family member views a decision that is positive for one family member quite negatively. Change will sometimes be easy and swift, but more often it will be slow and incremental. There is no guarantee that treatment will yield positive or intended results. During treatment, I am likely to draw on various approaches according to the presenting issues and what may benefit you.
_____ Initial

Discussion of Treatment Plan: Within a reasonable time after the initiation of treatment, I will discuss my understanding of your problem, goals for treatment and a plan. You have the right to ask about treatment and the risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical responsibility to advise you of your treatment options.
_____ Initial

Termination: In the first sessions, we will both assess whether I can be of benefit to you. If not, I will provide you with a number of referrals that you can contact. If at any time during the treatment, I assesses that I have not been effective in helping you reach your therapeutic goals, I am obligated to discuss this with you and, if appropriate, to terminate treatment. In such a case, I will provide you with a number of referrals that may be of help to you. You have the right to terminate treatment at any time. Also, the length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. We will collaborate regarding a plan for termination as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.
_____ Initial

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier to process the claims. If you so instruct, only the minimum necessary information will be communicated to the carrier. Please see HIPPA Privacy Rule Forms for further information.
_____ Initial

Confidentiality: All information disclosed within sessions and the written records pertaining to those sessions is confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law.
Minors and Confidentiality: 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, in the exercise of clinical and professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Minors and their parents are urged to discuss any questions or concerns that they have on this topic with me, however, please note that I will

initiate communication regarding this topic as needed during our initial session and throughout the process of working together as needed.
_____ Initial

Dual Relationships: Social and nonprofessional contact is unethical and will be addressed as needed. Please note I do not enter into social/dual relationships with clients. Also if we see each other in public outside of the office, to protect your confidentiality I will not initiate contact with you, however, if you choose you can initiate contact. Please let me know here if you have a specific request if we do see each other in public (i.e. if you would like me to initiate contact or vice versa): _____
_____ Initial

Documentation Requests: There is a charge for any documentation requests such as letters (200.00 fee per hour although this may vary depending upon the request) as well as any other documentation such as copies of treatment records. There will be a fee of $ 0.50 each page requested for treatment records. This fee may vary and will be discussed on an individual basis as related to the number and type of documentation requested, and this therapist will decide on an individual basis whether or not any documentation will be provided. Please note: typically this therapist does not engage in letter writing for any client, as this could be a conflict of interest, as the role of the therapist does not necessarily include being an advocate outside of the therapy session, with the exception of advocating for treatment services through your insurance company.

When Disclosure is required by Law: Some of the circumstances where disclosure is required by law include: Where there is reasonable suspicion of child, dependent or elder abuse or neglect, or where a client presents a danger to self or others.
_____ Initial

When Disclosure MAY be required: Disclosure may be required by law if you present a danger to yourself. Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the treatment records and/or testimony by me, your therapist.
_____ Initial

Litigation Limitations: Because of the nature of treatment, it is agreed that should there be a legal proceeding, neither you, nor your attorney nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding. Please note if a client does request this therapist be pulled into legal proceedings, a fee of $200 per hour will be in effect, including travel and court appearances. This fee will be requested up front before any engagement in court proceedings and the client will be held responsible for paying this fee.
_____ Initial

Case Consultation: The purpose of case consultation is to enhance a family's access to an appropriate array of services. Case Consultation with other professionals and colleagues may be beneficial to help improve treatment outcomes when such consultation is in the best interest of the client. By signing here you approve Case Consultation with other professionals and colleagues. Please note that all identifying information will be kept confidential during Case Consultation.
_____ Initial

Email/Texting: EMAILS, TEXTING, CELL PHONES, COMPUTERS AND FAXES: It is very important to be aware that computers and email and cell phone communication can be relatively easy to access by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such unauthorized access because servers have unlimited and direct access to all emails that go through them. Additionally, my emails are not encrypted, and faxes can be sent
erroneously to the wrong address. My computers are equipped with a firewall, a virus protection and a password, and all confidential information will be backed up on a regular basis. The information backed up will be stored securely off-site. Please note I do not communicate by way of fax, email, or text messaging.
_____ Initial

Electronic Communications: I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. You are also advised that any email sent to me through computer in a work-place environment is legally accessible by an employer. I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. I am ethically and legally obligated to maintain records of each time we meet, talk on the phone. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. A judge can subpoena your records for a variety of reasons, and if this happens, I must comply.
_____ Initial

Electronic Communications: Please note that I will not return your text or email messages due to phone being my preferred way of communication. If you send a text or email, I will not respond. Please contact me by way of phone for a timely response.
_____ Initial

Social Media Policy: Friending: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.
_____ Initial

Internet Searches: While my present or potential clients might conduct online searches about my practice and/or me, I do not search my clients with Google, Facebook, or other search engines unless there is a clinical need to do so, as in the case of a crisis or to assure your physical wellbeing. If clients ask me to conduct such searches or review their web sites or profiles and I deem that it might be helpful, I will consider it on a case by case basis and only after discussing the possible impact to our professional relationship and your privacy.
_____ Initial

I have read and understand the office policies.

_____

Client Name Printed Date Client Signature

If a minor (under age 18) is the client, parent/guardian signature below is indication of permission to treat.

_____

Minor Name Printed Minor's Age

_____

Parent/Guardian Name Printed Date Parent/Guardian Signature

I have reviewed these policies with my client.

_____

Clinician Signature Date