Office Policies & General Information
Agreement for Reunification Counseling Services

Wendy A. Campbell, MFT
Individual and Family Counselor

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are privileged and confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. A brief summary and conclusion report may be required for the courts at the conclusion of reunification therapy.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the 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 is gravely disabled.

When Disclosure May Be Required: 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 psychotherapy records and/or testimony by me, Wendy A. Campbell, MFT. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless I am authorized to do so by all adult family members who were part of the treatment.

Health Insurance & Confidentiality of Records: I do not contract with insurance companies as a network provider, so I am only responsible and accountable to you. My loyalties are not divided and there is no conflict of interest. Your health insurance policy is a contract between you and your insurance company. Since I am not a party to that contract, I would be considered an out of network provider. I will provide an invoice you can submit to your insurance company for reimbursement. Please specify that you intend to submit an insurance claim. The insurance claim form I supply will be filled out in such a way the client will receive direct reimbursement.

_____ Yes, I will need an insurance claim form

Consultation: I consult regularly with other professionals regarding my clients; however, neither clients' names, nor any other identifying information, are ever mentioned. My client's identity remains completely anonymous and confidentiality is fully maintained.

Your Right to Review Records: Both the law and the standards of my profession require that I keep appropriate treatment records. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. In such a case I will provide the records to an appropriate and legitimate mental health professional of your choice. Considering these exclusions, if it is still appropriate, upon your request, I will release information to any agency/person you specify unless I assess that releasing such information might be harmful in any way.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please leave a message on my answering machine (916) 965-7319 and your call will be returned as soon as possible. I check my messages a few times each day, unless I am out of town. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away call Sutter Center for Psychiatry at (916) 386-3077, or the Police/Sheriff's Department (911).

PAYMENTS & INSURANCE REIMBURSEMENT: There is a $1,800.00 retainer required for reunification counseling. Each 50 minute session will be deducted at the rate of $180.00 per session

from the retainer. The retainer allows for ten hours of work. Often times, given the nature of the situation it requires more than ten sessions to accomplish the desired results.

THE PROCESS OF REUNFICATION COUNSELING: Reunification counseling begins with the therapist meeting with both parents individually when appropriate; and with each child separately for at least two sessions. The parent desiring reunification and the child(ren) will then be brought together. Pursuing reunification in no way guarantees a specific result, there are times when the issues related to the case impair the accomplishment of reconnecting parent with child.

Referrals: If in the course of our working together I determine that I can not assist you to the full degree you are in need of, I will refer you to another professional(s) who would likely be more able to assist you in your efforts to produce change and growth in your life.

Duel Relationships: Therapy never involves sexual or business relationships or any other dual relationship that impairs the therapist's objectivity, clinical judgment, therapeutic effectiveness or can be exploitative in nature.

Reports and Consultation: A minimum fee of one hour is charged for all reports based on my hourly rate. Telephone calls and professional consultations, with physicians, attorneys or others as needed related to your treatment or your child's treatment will be prorated and billed to you at the hourly rate. I will discuss this with you prior to making these contacts. Please notify me immediately if you think you will need a psychotherapist for court testimony. Court rates are $180 per hour and are to be paid in full prior to the court date based upon the number of hours needed to clear my schedule.

CANCELLATION: Appointments are arranged so that we share a consistent, ongoing weekly or biweekly scheduled time together. If your appointment must be canceled, a minimum of **48 hours** prior notice is expected to avoid being charged for that session. This will allow enough time to schedule someone else in to your time slot. You will also be charged if you "No Show" for your scheduled time. **No Exceptions.**

My Agreement to You: I agree to assist you in gaining awareness and understanding of the obstacles you face, and to help you gain new skills to make healthy choices in your life, however, this in no way guarantees that the changes you would like to have happen will occur.

I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with them.

Client Name (print)	Date	Signature

Client Name (print)	Date	Signature

Wendy A. Campbell, MFT

Therapist	Date	Signature