Marcie Scranton, PsyD, MFT
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www.marciescranton.com
424-652-8520

Couples Informed Consent

Practice Policies:

Fees and Cancellations:
The fee for a 50-minute session is $225.00, which is payable at the beginning of each session unless we make other arrangements.* Longer sessions are charged on a pro rata basis. Sliding scale fees may be re-evaluated should your circumstances change. Scheduled increases may also occur with advance notice. I do not charge for brief phone calls between sessions. Telephone and video sessions are billed at the usual fee.

*In the case of a fee modification, we agree that your fee will be _____.

We will set aside a specific day and time for your sessions. If you must cancel for any reason, it is necessary to do so at least 24 hours in advance to avoid a charge for the session. If you have arrived at my office for a scheduled session and I am not able to see you at that time, I will provide a session at no charge.

For clients wishing to bill insurance:
I accept Cigna insurance. If you wish to bill another insurance company, I will provide a superbill for you to submit to your insurer; however, I cannot guarantee that you will receive reimbursement. *Responsibility for payment ultimately resides with you as per our agreement, as are any fees not reimbursed by your insurer or other third-party payer; this includes a standard $50 charge for a late cancellation or missed appointment.* Please be sure to check your benefits before we start treatment. Copay/coinsurance and charges against deductible vary, and may change during the course of treatment. I will make every effort to avoid you being presented with any unexpected charges. Please be aware that insurance reimbursement may affect confidentiality (see #5 on page 3). If you do not plan to use your insurance benefits, please let me know.

** Your copay/coinsurance (subject to EOB and any changes) _____.

Emergencies:
My phones are equipped with confidential voice mail. I will make every effort to return calls as soon as possible. In the event that you are feeling unsafe or require immediate medical or psychiatric assistance, please call 911, or go to the nearest emergency room.

What to Expect:

Benefits and Risks of Psychotherapy:
Psychotherapy is a process in which we discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so that you can experience life more fully. Progress and success may vary depending upon the particular problems or issues being addressed, as well as other factors. Participating in therapy can result in a number of benefits, including decreased stress and anxiety, negative thoughts, self-sabotaging behaviors, and dependence on medication and addictive substances, as well as improved relationships, greater comfort in social, work, and family settings, better capacity for intimacy, and improved self-confidence. Such benefits may entail your active participation in the therapeutic process, honesty, and a willingness to change. Of course, there is no guarantee that therapy will yield any or all of the benefits listed above. Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. There may be times in which I challenge your perceptions and assumptions, and offer different perspectives. The process may evoke strong feelings of sadness, anger, fear, etc. and may result in unintended outcomes, including changes in personal relationships. Naturally, any decision on the status of your personal relationships lies with you.
During the therapeutic process, some patients find that they feel worse before they feel better. This is often normal. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Please address with me *any* concerns you have regarding your progress.

Psychotherapist-Patient Privilege:
Your information is subject to psychotherapist-patient privilege. Typically, the patient is the holder of privilege. If I receive a subpoena for records or testimony, I will assert privilege on your behalf until instructed otherwise in writing by you or your representative. To protect your confidentiality, I will not voluntarily participate in litigation or custody dispute in which you are a party. Should I be compelled to appear as a witness in an action in which you are involved, you agree to reimburse me for time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual hourly rate.

My Background:
I have been practicing since 2010, working with individuals in stages of life transition, recovery, crisis, grief, stress, family issues, anxiety, and depression, as well as with couples in premarital counseling and relationship conflict, and with children experiencing emotional difficulties. Additionally, I am certified in Strategic Parenting and Trauma-Based CBT. My theoretical orientation is based on Humanistic/Existential, Cognitive-Behavioral, Psychoanalytic, and Solution-Focused models.

Limits of Confidentiality:
Communication between therapist and patient is both privileged and confidential. This means I generally cannot discuss your case with anyone without your authorization. However, a therapist has an ethical and/or legal obligation to break confidentiality under the following circumstances:

1. If you intend to harm another person, I am legally bound to warn the authorities and/or the person, or the family of the person, of your report of intent to harm.
2. If you disclose that you, or someone you know, was in the past or is currently involved in child abuse, elder abuse, or abuse of a disabled or dependent person, I am legally required to make a report to the appropriate agency.
3. If you pose a life-threatening danger to yourself, it is my duty to warn the authorities and/or your family members.
4. If you become involved in legal proceedings that concern your medical or mental health, you may be waiving some of your rights to confidentiality, and your records may be subpoenaed. Questions regarding the limits of confidentiality under those circumstances should be discussed with your attorney.
5. If you seek insurance reimbursement, you may be waiving your right to confidentiality. If your sessions are covered by insurance, your insurer will require, at a minimum, a diagnosis and dates of treatment.

Professional consultation is an important component of a beneficial psychotherapy practice. As such, I may occasionally participate in consultation with appropriate professionals. At no time will I reveal any identifying information about you.

Patient Rights and Responsibilities:
In addition to your right to confidentiality, you have the right to end your therapy at any time, for any reason you deem appropriate, without any obligation except for fees already incurred. You may also question any aspect of your treatment and, should I not meet your needs, I will refer you appropriately. I may also need to end our relationship if there is a conflict of interest, if your needs are outside of my scope of competence or practice, or for nonpayment of fees. In most cases I will recommend that we have one or more termination sessions to facilitate a positive closure experience and give us an opportunity to reflect on the work that has been done. You may also expect that I will maintain professional and ethical boundaries with you by not entering into any personal, financial or professional relationship that could compromise our therapeutic relationship. The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Those who do not have or are not using insurance have the right to receive a "Good Faith Estimate" explaining how much your medical care may cost, excluding non-emergency services, at least 1 business day before your services begin. For more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

Electronic Communication and Teletherapy:
If and when teletherapy is an option, the same rights and exceptions regarding confidentiality, fees, and responsibilities as in-person sessions apply. I provide a secure platform for virtual sessions and take care to conduct phone or video sessions in a protected space. However, sessions may occur in areas such as a patient's home, where others may be present. Please be aware of your surroundings. Information that may be significant, such as body language, may not be as easily communicated as it is in person. In addition, transmission difficulties sometimes occur, so I ask that we have a backup plan to keep things as uninterrupted as possible, for example, by switching to a different medium if necessary. I may need to verify your identity and location at the beginning of sessions. I do not record any teletherapy sessions without your express written consent.

To further ensure your confidentiality, I recommend that emails, texts and other traceable information not contain any sensitive material.

Most insurance companies cover teletherapy but plans may differ. If you are planning to use your insurance, please check your coverage, especially out-of-network.

Confidentiality Addendum: For Couples and Families
If you are seeing me for couples or family therapy please be aware that you (the individual) are not the patient. Rather, the couple or family is the patient, and chart notes are kept accordingly. Any decisions to release records necessitate that both members of the couple, or all adult family members, sign a written release.

For couples, in order to build trust and to highlight the nature of our work, I commit to a *"no secrets"* policy. Our work will begin when all parties are present. Any information conveyed to me – in person, by telephone or in writing – is considered to be open for discussion during our sessions. Do not communicate with me about any matter you would not be prepared to discuss in session. I will assist you in discussing any difficult issue with your partner.

I/we have read and understand the foregoing, agree with its terms, and consent to treatment with Marcie Scranton, LMFT.

Name/s (Print):

_____ /_____

Signature _____ *Date* _____

Signature _____ *Date* _____

It is understood that by signing, adult members are granting permission for any minor children, if clinically appropriate, to take part in sessions.

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Each person completes separately:

Name_____ Date of Birth_____

Address_____ City_____ Zip_____

Referred by_____

Phone #_____ email: _____

Are there any restrictions on leaving messages? _____

Marital Status_____ Name of Spouse or Partner_____

Children and ages _____

Occupation _____ Employer_____

Emergency Contact (name, address and phone number) _____

_____

Previous Psychotherapy (with whom and when) _____

_____

Psychiatric Hospitalizations (date and reason for admission) _____

_____

Have you ever made a suicide attempt? If so, please indicate date and method used:

_____

Are you currently having suicidal thoughts? Yes_____ No_____

Please list any medications (past and present) and purpose of each: _____

_____

Why are you seeking therapy at this time? _____

_____

Any problems in your work life? _____

_____

Any problems in your relational life? _____

_____

If therapy is helpful, how will your life change? _____

_____

Are you currently under a physician's care? _____

Please indicate if any of the following currently apply:

Depression ☐	Headaches ☐
Anxiety ☐	Digestive Problems ☐
Panic Attacks ☐	Fatigue ☐
Disordered Eating ☐	Dizziness ☐
Explosive Anger ☐	Allergies ☐
Sexual Problems ☐	Injuries/Accidents ☐
Drinking Problem ☐	Cancer ☐
Drug Problem ☐	Heart Condition ☐
Memory Problems ☐	Chronic Pain ☐
Difficulty Concentrating ☐	Sleep Problems ☐

Other: _____

_____

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Panic Attacks ☐	Fatigue ☐
Disordered Eating ☐	Dizziness ☐
Explosive Anger ☐	Allergies ☐
Sexual Problems ☐	Injuries/Accidents ☐
Drinking Problem ☐	Cancer ☐
Drug Problem ☐	Heart Condition ☐
Memory Problems ☐	Chronic Pain ☐
Difficulty Concentrating ☐	Sleep Problems ☐

Other: _____

_____