Lia Roy, LMFT

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Welcome to my practice. In order to support you in your therapeutic process and to make sure I have clearly communicated my policies and procedure, please review these documents.

INFORMED CONSENT & OFFICE POLICIES

Litigation Limitation In the opinion of the U.S. Supreme Court (Jaffee v. Redmond, 1996), "the mere possibility of disclosure of the confidential communication may impede the development of the relationship necessary for successful treatment." Therefore, any therapy that is subject to court disclosure is greatly compromised. In the interest of maximizing therapeutic outcome, these sessions will be entered in for treatment purposes only. Should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), it is agreed that neither you or your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, no will a disclosure of the psychotherapy records be requested. It is further understood that a qualified forensic psychologist should be contacted if an evaluation or opinion is needed for legal purposes. Additionally, health insurance does not pay for court related evaluations, reports, letters, and/or correspondence.

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Financial Terms Payments are due and payable at each session unless other arrangements are made (sessions are usually 45-50 minutes long). Telephone conversations, site visits, report writing and reading, consultation with other professionals, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed otherwise. There is a medical records handling charge of $50.00 per request to release records to cover the cost of time, and copies and postage for closed charts. Returned checks are subject to a $25 charge. Payment that is over 30 days late will accrue interest at the rate of 1.5% monthly.

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Insurance Coverage Counseling expenses are your responsibility regardless of insurance coverage. It is your responsibility to verify the specifics of your mental health benefits so that misunderstandings do not occur. Not all conditions/ problems, which are the focus of psychotherapy, are reimbursed by insurance companies. It is also your responsibility to obtain prior authorization for treatment from your insurance carrier. I will bill your insurance, however, you are responsible for co-payments amounts and deductibles as set by your benefit plan. For modalities of treatment not covered by your benefit plan, a written agreement needs to be signed between you and my office. At any time during treatment, should your coverage change or you become ineligible for insurance coverage, you must notify my office immediately. Any sessions uncovered due to changes in insurance will become your responsibility.

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Cancellation and Missed Appointment Policy Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for re-scheduling or cancelling appointment. The full fee will be charged to you for sessions missed without such notification. Your insurance does not reimburse for missed sessions. Repeated "no shows" will result in referral back to your insurance company for reassignment to another therapist.

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Mediation & Arbitration All disputes arising out of or in relation to this agreement to provide psychotherapy services shall be first referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of my office and the patient. The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Los Angeles County, in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, my office can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum as and for collection of attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

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Contact Regular appointments can be scheduled by texting my office @ (818) 515-4576 or via voicemail or emailing a request to Lialistens@yahoo.com. If your call is urgent, leave my office a message. I monitor my voicemail frequently and will make every effort to return your call as soon as possible. Calls are usually returned within 24 hours or less with the exception of weekends and holidays. During after-hours I cannot guarantee a phone response within a certain period of time; if you are unable to reach me and cannot wait, call your family physician, go to the nearest emergency room or call 911. If I plan to be on vacation, I will provide you with exact dates that I will be out of the office.

Initial here _____

Consent to Treatment In order to be most helpful, clients must not be under the influence of any intoxicating substance, such as alcohol or any other drugs. If so I may feel it necessary to reschedule your appointment and charge you with a cancellation fee. I look forward to a positive relationship with you and strive to provide quality treatment. Thank you for your attention to this matter. My signature acknowledges that I have read and understand the above explanations regarding Informed Consent and Office Policies. I agree to enter into psychotherapy relationship under the terms outlined above. In regard to a minor patient, I am the legal guardian or legal representative of the patient and have the legal right to authorize treatment for this patient.

PATIENT'S NAME _____

PATIENT'S NAME _____

PATIENT'S NAME _____

SIGNATURE_____ DATE _____

SIGNATURE_____ DATE _____

SIGNATURE_____ DATE _____

(Parent's or Guardian's signature, if patient is a minor)

SIGNATURE_____ DATE _____

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