ELIZABETH RAE WALKER, MA, MFT, MBA

Licensed Marriage and Family Therapist

MFT 31203

23 Altarinda Road, Suite 216

Orinda, CA 94563

510-325-6060 Cell

Tax ID: 551062670

NPI 1326625690

**Information About Your Therapist**

At an appropriate time, your therapist will discuss his/her professional background with you and provide you with information regarding his/her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist’s background, experience and professional orientation.

**Note:** The therapist should indicate his/her licensure status before the patient completes this form.

Your therapist is a:

**Licensed Marriage and Family Therapist**

**Fees and Insurance**

The fee for service is $ for individual or marital/family therapy session.

Individual Sessions and conjoint (marital /family) sessions are approximately 50 minutes in length.

Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure.

If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

**Confidentiality**

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, your therapist will not disclose information communicated privately to him or her by one family member, to any other family member without written permission.) There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child, dependent adult or elder abuse. Therapists may also be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself.

If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that your therapist utilizes a “no-secrets” policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family.

Please feel free to ask your therapist about his or her “no secrets” policy and how it may apply to you.

**Appointment Scheduling and Cancellation Policies**

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hours in advance of your appointment. If you do not provide your therapist with at least 24 hours’ notice in advance, you are responsible for payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions.

INITIAL: \_\_\_\_\_\_\_\_\_\_ INITIAL: \_\_\_\_\_\_\_\_\_\_

**Therapist Availability/Emergencies**

You are welcome to phone your therapist in between sessions. However, as a general rule, it is our belief that important issues are better addressed within regularly scheduled sessions.

You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non urgent phone calls are returned during the therapist’s normal workdays within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist’s voicemail. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. You should be aware that your therapist is generally available to return phone calls within approximately 24 hours.

If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist’s voicemail message.

**In the event of a medical or psychiatric 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 the following resources that are available in the local community to assist individuals who are in crisis:

National Suicide Prevention Lifeline: 1-800-273-8255

Alameda County Crisis Support Services: 1-800-309-2131

National Domestic Violence Hotline: 1-800-787-3224

Contra Costa Domestic Violence Assistance and Help: 888-215-5555

Bay Area Women Against Rape: 1-510-430-1298

Emergency Assistance: 911

**Therapist Communications**

Your therapist may need to communicate with you by telephone or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

My therapist may call me on my home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My therapist may call me on my cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My therapist may send a text message: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My therapist may call me at work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My therapist may communicate with me by e-mail. My e-mail address is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sensitive, clinical information is to be discussed over the phone or in-person as deemed appropriate by the therapist. For appropriate e-mail or text communication therapist will respond to your e-mail or text within 24 hours. Potential risks of using electronic communication may include but are not limited to: inadvertent sending of an e-mail or text containing confidential information to the wrong recipient, theft or loss of the computer, laptop or mobile device storing confidential information, and interception by an unauthorized third party through an unsecured network. E-mail messages may contain viruses or other defects and it is your responsibility to ensure that it is virus-free. In addition, e- mail or text communication may become part of the clinical record. You may be charged for time the therapist spends reading and responding e-mail or text messages.

**About the Therapy Process**

It is your therapist’s intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation; your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist’s recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Your therapist will work with you to develop an effective treatment plan. Over the course of therapy, your therapist will attempt to evaluate whether the therapy provided is beneficial to you. Your feedback and input are an important part of this process. It is the goal of your therapist to assist you in effectively addressing your problems and concerns. However, due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

**Notice to Patients Pertaining to Complaints**

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of **[Insert your license or registration category. For example: “licensed marriage and family therapists,” “associate marriage and family therapists,” etc.]** You may contact the board online at www.bbs.ca.gov, or by calling (916) 574- 7830.

INITIAL: \_\_\_\_\_\_\_\_\_\_ INITIAL: \_\_\_\_\_\_\_\_\_\_

**Good Faith Estimate Notice**

You have the right to receive a “Good Faith Estimate” explaining how much your medical and mental health care will cost.

Under the law, health care providers need to give patients who don’t have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services.

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services.

You can ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.

If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises).

INITIAL: \_\_\_\_\_\_\_\_\_\_\_ INITIAL: \_\_\_\_\_\_\_\_\_\_

**Telehealth**

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care.

**By signing this form, I understand and agree to the following:**

1. I have a right to confidentiality regarding my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the [Informed Consent Form or Statement of Disclosures] I received from my therapist also apply to my Telehealth services.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and my therapist may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.
6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.
7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party’s written permission.
9. I have discussed the fees charged for Telehealth with my therapist and agree to them and I have been provided with this information in the Informed Consent.
10. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

INITIAL: \_\_\_\_\_\_\_\_\_\_ INITIAL: \_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

I am required by law to maintain the privacy and security of your protected health information (“PHI”) and to provide you with this Notice of Privacy Practices (“Notice”). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization (“Authorization”). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

**Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent**.

**I can use and disclose your PHI without your Authorization for the following reasons:**

**For your treatment**. I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.

**To obtain payment for your treatment**. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.

**For health care operations**. I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

**Certain Uses and Disclosures Do Not Require Your Authorization**. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.

For health oversight activities, including audits and investigations.

For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

For law enforcement purposes, including reporting crimes occurring on my premises.

To coroners or medical examiners, when such individuals are performing duties authorized by law.

For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

Specialized government functions, including**,** ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter- intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

**Marketing**. As a psychotherapist, I will not use or disclose your PHI for marketing purposes**. Sale of PHI**. As a psychotherapist, I will not sell your PHI in the regular course of my business.

**Psychotherapy Notes: I do not keep “psychotherapy notes” as that term is defined in 45 CFR§ 164.501.** I maintain a record of your treatment and you may request a copy of such record at any time, or you may request that I prepare a summary of your treatment. There may be reasonable, cost-based fees involved with copying the record or preparing a summary.

**Certain Uses and Disclosures Require You to Have the Opportunity to Object.**

**Disclosures to family, friends, or others**. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

**YOUR RIGHTS REGARDING YOUR PHI** You have the following rights with respect to your PHI:

**The Right to Request Limits on Uses and Disclosures of Your PHI**. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.

**The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

**The Right to Choose How I Send PHI to You**. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

**The Right to See and Get Copies of Your PHI**. You have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree.
to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.

**The Right to Get a List of the Disclosures I Have Made**. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.

**The Right to Correct or Update Your PHI**. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.

**The Right to Get a Paper or Electronic Copy of this Notice**. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

**HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES** If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice, and my address and phone number are:

23 ALTARINDA ROAD, SUITE 216, ORINDA, CA 94563

PHONE: 510-325-6060.

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

**1.** Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;

**2.** Calling 1-877-696-6775; or,

**3.** Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
I will not retaliate against you if you file a complaint about my privacy practices.

INITIAL: \_\_\_\_\_\_\_\_\_\_ INITIAL: \_\_\_\_\_\_\_\_\_\_

“No Secrets” Policy for Family Therapy and Couple Therapy

This written policy is intended to inform you, the participants in family therapy or couple therapy, that when I agree to work with a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (the treatment unit).

During my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since these sessions can and should be considered a part of the family or couple therapy, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit — that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to treat the patient (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned during an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with Elizabeth Rae Walker, MFT the therapist), and that we enter couple/family therapy in agreement with this policy.

INITIAL: \_\_\_\_\_\_\_\_\_\_ INITIAL: \_\_\_\_\_\_\_\_\_\_

**Termination of Therapy**

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. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you 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.

**Your signature indicates that you have read this agreement for services carefully and understand its contents.**

**Please ask your therapist to address any questions or concerns that you have about this information before you sign.**

Printed Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Printed Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature Date