TRUTH FAMILY AND CHILD COUNSELING SERVICES, INC.
LAURA MONDRAGON, LMFT #82979, CCTP
951-956-4244

THERAPEUTIC CONTRACT

A. The Treatment Process

Engaging in counseling and psychotherapy can result in many benefits to you. These include a better understanding of your own goals and values, improved interpersonal relationships, resolution of specific life issues/concerns, as well as improved well-being and a decrease of troubling mental health symptoms. Working to gain these benefits in therapy, however, requires effort on your part and may result in your experiencing some discomfort. Change can sometimes be swift and easy, while more often it can be slow and sometimes, frustrating. Remember, resolving significant life events, either current or past, in therapy can bring on strong feelings of anger, depression, fear, and at times increase uncomfortable symptoms related to mental health. Resolution of issues in your personal life, your relationships, or your family interactions can also lead to discomfort and may bring about changes that were not originally foreseen or intended.

B. Client's Rights

1) You have the right to a confidential relationship with your therapist within certain legal limitations (See # 3 and # 4). Information revealed by you during the course of therapy will be kept confidential and will not be revealed to any person without your written permission with an exception of a few legally required reporting mandates (see #4).

2) You have the right to know the content of your records at any time and I have the right to provide you with records or a summary of the records. This requires a written request and for a nominal fee. The treating therapist will determine if a summary would be appropriate in certain circumstances in order to preserve the therapeutic relationship. There is a specific time line, by law, of when the therapist is required to provide you of those records / summary.

3) With your written request/signed release, I can release any <u>specified</u> part of your records on file to the person/entity you indicate.

4) Under certain legally defined situations, your therapist has a duty to reveal information you disclose during the course of therapy to other persons <u>without</u> your written consent. <u>I am not required to inform you of these legally defined situations</u>, which include but are not limited to:

a) Revealing to your therapist active child abuse or neglect. If an alleged perpetrator is in contact with minors and there is a reasonable suspicion that he/she may still be abusing minors:

b) Active/current abuse of a dependent adult or an elder is revealed in the process of therapy.

c) If you seriously threaten harm or death to another person, I will attempt to contact you to inform you of that statement along with the other person and potentially a local law enforcement agency. I may be subpoenaed at a later date regarding these threats or appropriate clinical action taken. (See additional information regarding Subpoena's under fees for services.)

f) If you are in a lawsuit claiming emotional harm, the opposing side may Subpoena your therapy records.

5) You have the right to ask questions about any of the procedures used in the course of your therapy.

6) Should you choose not to enter therapy with me, I can provide you with names of other qualified professionals or agencies that have counseling services in your area so that you might choose whose services would best assist you in your goals.

7) You have the right to terminate therapy with me at any time without any financial, legal, or moral obligations other than those you've already incurred or treatment you have already received. I also have the right to terminate therapy with you under the following conditions:

a) When your therapist determines that therapy is no longer beneficial to you.
b) When you refuse to cooperate with treatment.
c) When I believe that you will be better served by another professional or agency.
d) Unless special fee arrangements have been made. Example, when you have not paid for the last two sessions.
e) When you have failed to show up for your last two therapy sessions without giving 24-hour notice, as is required by my office policies.
f) If I determine, during the first three sessions, that your therapist cannot help you, I can assist you in finding a qualified professional. If I have your written consent, I can provide your new professional with information they request. If any of these situations apply, I will send you a certified letter to your address of record to inform you of our decision and I will give you the names of several therapists /therapy agencies for your future counseling needs.

8) As life can bring unexpected circumstances, if I am unable to continue your therapy, another therapist will contact you to discuss what would be best for you, at that time.

C. Fees, Payment Agreement, and Length of Treatment

PRIVATE PAY AGREEMENT

I agree to enter therapy with therapist, Laura Mondragon, LMFT, CCTP for a minimum of ____50____fifty minute (clinical hour) session during the next __OPEN_____ weeks/months. The fee is $_____per clinical hour. After this initial period, therapy can be continued under this agreement. I am entering therapy with TRUTH FAMILY CHILD AND COUNSELING SERVICES, INC. C/O LAURA MONDRAGON, LMFT, CCTP , and have decided to forego using any Health Insurance benefits that I may be eligible for and engage in therapy services on a private fee for service basis with TRUTH FAMILY CHILD AND COUNSELING SERVICES, INC. C/O LAURA MONDRAGON. She is not responsible for submitting any Health Insurance paperwork and I understand that any Health Insurance benefits that I may have are not being applied to the services TRUTH FAMILY CHILD AND COUNSELING SERVICES, INC. C/O LAURA MONDRAGON is providing me. A receipt for services rendered will be provided upon my request.

Date: _____ Client's Signature: _____

Date: _____ Client's/Guardian's Signature: _____

Date: _____Therapist's Signature: _____

PAYMENTS/CO-PAYMENTS/THERAPY PROCESS/SUBPOENAS (initial and sign)

I will make payment of standard session fee through PayPal at the beginning of the therapy appointment. I understand that I can leave therapy at any time and that I have no financial, legal, or moral obligation to complete additional sessions or any future scheduled appointments. I am contracting only to pay for:

1.) Completed therapy sessions; Initials_____
2.) Full session fee for sessions I miss without providing 24-hour notice as outlined in the Office Policies section. Initials_____
3) I understand that there are additional fees to be paid to TRUTH FAMILY CHILD AND COUNSELING SERVICES, INC C/O LAURA MONDRAGON when a treating therapist is subpoenaed for Court proceedings. Generally, an appearance can cost from $350.00 – $600.00. I understand that LAURA MONDRAGON will determine the specific fee on a case by case basis. I understand I am responsible for this fee and I understand it must be paid in full (3) three business days prior to the hearing. These funds will be applied to your final fees for services. I understand that these fees are non- refundable. Initials _____.

Date: _____ Client's Signature: _____

Date: _____ Client's/Guardian's Signature: _____

Date: _____ Therapist's Signature: _____

D. Consent to Provide Treatment

I _____ (name) authorize and request that the therapist, carry out psychotherapeutic examinations, diagnostic procedures, and or treatments which now or during the course of my care as a client are advisable. I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I have read and fully understand this Consent for Treatment Form.

Date: _____ Client's Signature: _____

Date: _____ Client's/Guardian's Signature: _____

Date: _____ Therapist's Signature: _____

E. Acknowledgement of Receiving Notice of Privacy Practices

I have been provided a copy of the Notice of Privacy Practices (PHI) and provide this acknowledgement to TRUTH FAMILY AND CHILD COUNSELING SERVICES, INC C/O LAURA MONDRAGON that I have been informed about my rights and clinicians responsibilities related to my protected health information (PHI).

Date: _____ Client's Signature: _____

Date: _____ Client's/Guardian's Signature: _____

Date: _____Therapist's Signature: _____

F. Office Policies Payment for Service:

TRUTH FAMILY AND CHILD COUNSELING SERVICES, INC.
LAURA MONDRAGON, LMFT #82979, CCTP
951-956-4244

Payment for services is expected at the **beginning** of your appointment through PayPal unless other arrangements have been made. Please notify TRUTH FAMILY CHILD AND COUNSELING SERVICES, INC. C/O LAURA MONDRAGON if any problems arise regarding your ability to make timely payments.

I understand that I shall pay for services by payment through the PayPal application to LAURA MONDRAGON, TRUTH FAMILY AND CHILD COUNSELING SERVICES, INC., or to my business phone number at 951-956-4244.

Insurance Reimbursement:
Clients who carry Health Insurance Policies will have to ascertain if they are able to access out-of-network reimbursement from their own insurance. TRUTH FAMILY CHILD AND COUNSELING SERVICES, INC. C/O LAURA MONDRAGON will provide you with the appropriate billing receipt, which you can provide to your insurance company for reimbursement should you be eligible. TRUTH FAMILY CHILD AND COUNSELING SERVICES, INC. C/O LAURA MONDRAGON does not bill insurance companies. Please be aware that ALL insurance companies require a diagnosis for any reimbursements/billing.

Cancellation:
Since an appointment reserves time specifically for you, a minimum of 24-hour notice is required for rescheduling or cancellation of an appointment. The full fee WILL be charged for missed sessions without such notification (24-hours) prior to your session time.

Office Hours:
TRUTH FAMILY CHILD AND COUNSELING SERVICES, INC. C/O LAURA MONDRAGON OFFICE HOURS:

Tuesday AND Friday 10:00 AM- 8:00PM

Office Phone: 951-956-4244. Please note: It is much easier **and preferable to reach me via TEXT MESSAGING** with your return name and phone number as I am not able to access my voicemail *during meetings, sessions, etc.*

I will do my best to return your phone call within 24 hours.

Mental Health Emergency Procedure:

An emergency is an unexpected event that requires immediate attention and can be a threat to your health, well-being or safety. If an emergency situation arises, and you feel unable to handle it alone, please leave a detailed message on my voicemail or via text message. I will make every attempt to return your call as soon as possible. However, there are circumstances which may prevent me from returning your call immediately. If I have not called you back within 60 minutes and the emergency persists, or if the emergency requires it, please call your physician, call 9-1-1, or admit yourself to the nearest hospital for treatment and observation.

I have read and understand these office policies.

Date: _____ Client's Signature: _____

Date: _____ Client's/Guardian's Signature: _____

Date: _____Therapist's Signature: _____