

Jeff A. James MFT (# 49213)

Christian Counseling Centers, www.salinas-counseling.com

Addresses: 119 Cayuga St Salinas CA 93901 & 199 17th St Pacific Grove, CA 93950

Phone: (831) 206-6972, Fax: (831) 655-3939, Email: jeff@salinas-counseling.com

Disclosure of Policies

What I Do Here

Counseling is a process of personal exploration designed to increase your self-awareness and personal growth. This process may help you gain new understanding of relationships, explore new ways to deal with problems, and develop new personal skills.

At the same time, your involvement in this process involves some risks:

- You may experience feelings of unhappiness, anger, guilt, fear, and frustration.
- Your decisions to change behaviors may produce disruptions in your current life patterns and relationships.
- Although the benefits of counseling are well-documented, therapy is not always successful.

Treatment plans, goals, and methods will be discussed with you in the first session and at regular intervals. At any time you may ask questions about your progress or about the methods I use.

The Limits of What I Do Here

Generally, information revealed by you during sessions will not be shared with any person outside this office without your written permission.

Specifically, there are exceptions to confidentiality in which counselors are required by law to share information to persons or agencies without your permission.

- If you threaten to use violence against another person, I will inform the intended victim and law enforcement.
- If you threaten to use violence against yourself, I will take the appropriate actions to ensure your safety.
- If ordered by a court to testify about your therapy, I will claim "client-therapist privilege". If the judge does not honor this privilege, I will have to testify.
- If you are court-ordered to seek counseling, the results of the therapy may have to be revealed in court.
- If you report the abuse or neglect of a child, elder, or dependent adult, or if I suspect abuse or neglect, I will inform law enforcement.

When I Counsel Minors

I only treat minors with the signed consent of both parents who have legal custody. In the case of a divorce, I need a copy of the custody order.

Contacting Me

My contact information is in each page heading of this disclosure.

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When I am out of town, another counselor will take care of my practice. I will leave his or her contact information on my voicemail recording.

In an emergency, call 911 or go to the nearest hospital Emergency Room (ER): Community Hospital of the Monterey Peninsula (CHOMP), (831) 625-4623; Natividad Medical Center, (831) 755-4111; Salinas Valley Memorial Hospital (SVMH), (831) 755-0700.

What I Charge

My fee is \$ _____ for the first session and \$ _____ for each 50 minute session. Fees or co-pays are collected at the end of each session by cash, check, or credit card. Telephone calls over 15 minutes will be pro-rated at the hourly rate.

If you are using insurance, I send your claim to a billing service who will handle the filing with your insurance company and the collecting of any fees or portion of the cost for which you are responsible. If you have an insurance deductible, you will be billed for the cost of the session that your insurer does not pay.

I ask for a 24 hour notice of cancellation. For missed appointments with no notice, I charge \$ _____.

I will provide a monthly 'superbill' on request, which includes the diagnosis, session dates, and fees.

When Our Work Is Finished

Generally, counseling comes to an end when you and I agree on the goal(s) being met.

Specifically, you have the right to end counseling with me at any time and for any reason. You also have the right to ask me for referrals to other counselors in the community. If I end counseling, you have the right to know why.

By signing below, you are acknowledging you have read and agreed to these policies, have read the HIPAA notice, and have received a copy of this disclosure.

Client Signature _____ Date _____

I have discussed the above issues with the client and have no reason to believe he or she is not fully competent to give consent to treatment.

Counselor Signature _____ Date _____