James L Moog MA LMFT MAC BCETS

Individual, Couple & Family Therapy

1439 Cedarwood Lane, Suite B
Pleasanton, CA 94566
925-339-1964 / fax 925-838-4575
License MFT17484

Disclosure Statement & Agreement for Services

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents.

Information About Me

At an appropriate time, we can discuss my professional background. I can provide you with information regarding my experience, education, special interests, and professional orientation. You are free to ask questions at any time about my background, experience, and professional orientation. I am a Licensed Marriage and Family Therapist.

Fees and Insurance

The fee for service is $180.00 per individual therapy session.

The fee for service is $200.00 per conjoint (marital /family) therapy session.

Individual Sessions and conjoint (marital /family) sessions are approximately 50 or 100 minutes in length Fees are payable at the time that services are rendered. I do not bill or receive reimbursement through health insurance for services. Upon request, I will provide a receipt for each session so you may bill your insurance company.

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

Confidentiality

All communications between you and I 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, I 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. However, it is important that you know that I utilize a "no-secrets" policy when conducting family or marital/couples therapy which means that, if you participate in family, and/or marital/couples therapy, I will be permitted to use information obtained in an individual session that you may have had with me, when working with other members of your family. Please feel free to ask me about my "no secrets" policy and how it may apply to you.

There are exceptions to confidentiality. For example, according to law, 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 client presents a serious danger of physical violence to another person or when a client is dangerous to him or herself.

Minors and Confidentiality

Communications between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, I may, in the exercise of my professional judgment, discuss the treatment progress of a minor client with the parent or caretaker. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with me.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. I 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, I ask you to notify me at least 24 hours in advance of your appointment for a 50-minute session and 48 hours in advance for a 100-minute session unless cancellation was due to an emergency. If you do not provide me with notice in advance, you are responsible for payment for the missed session.

Therapist Availability/Emergencies

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

You may leave a message for me at any time on my confidential voicemail or text. If you wish me 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 my normal workdays within 24 hours. If you have an urgent need to speak with me, please indicate that fact in your message as well as, in the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, immediately 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 I generally check for messages between sessions and return messages between sessions. If unable, I will return phone calls in the evening.

You should also be aware of the following resources that are available in the local community to assist during a crisis:

(800) 309-2131	Alameda County
(888) 678-7277	Contra Costa County
(805) 278-4204	Santa Clara County
(800) 273-8255	National Suicide Prevention
(800) 273-8255	Veterans Crisis Line
(800) 799-7233	National Domestic Violence Hotline

Therapist Communications

I will 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 me 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 number at:_____

☐ My therapist may call me on my cell phone at: _____

☐ My therapist may send a text message to my cell phone (same as above):_____

☐ My therapist may call me at work at :_____

☐ My therapist may communicate with me by e-mail at: _____

☐ My therapist may send a fax to me at: _____

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

☐ My therapist may send mail to me at my work address at:_____

Sensitive, clinical information may be discussed over the phone or in-person as I deem appropriate. For appropriate e-mail or text communication I 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 I spend reading and responding to e-mail or text messages.

About the Therapy Process

As your Therapist, it is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with of my recommendations. I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

I will work with you to develop an effective treatment plan. Over the course of therapy, I 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 my goal 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 client, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

Cessation of Therapy

The length of your treatment and the timing of the eventual stopping of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for the end of your treatment. Together we can discuss a plan for concluding your treatment as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If we determine that you are not benefiting from treatment, either of us 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 me to address any questions or concerns that you have about this information before you sign.

Print Client Name_____ Signature_____

Date:_____