

**Break Thru Counseling Center**  
**4012 Katella Ave., Suite 205**  
**Los Alamitos, CA 90720**

Break Thru Counseling Center is a non-profit corporation serving the local community. We are counselors with a variety of training and experience. We want to assure you of the utmost confidentiality in matters you discuss with your counselor. If the need arises, your case may be reviewed with another counselor, but your identity would remain anonymous. No other information will be released concerning your identity or personal life without your express written consent, unless otherwise mandated by law (see "Confidentiality Statement" agreement.)

## **Therapeutic Contract**

### **The Therapy Process**

Participating in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part and may result in you experiencing considerable discomfort. Change will sometimes be easy and swift, but more often it will be slow and frustrating. Remembering and resolving significant life events in therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended. The therapeutic process incorporates several techniques including, insight, interpretation, cognitive/behavioral restructuring, teaching and modeling communication skills, drawing, sand tray, parts work, experiential exercises, reframing, dream analysis, educating about individual and family patterns and games, relaxation techniques, and various pencil and paper tests.

### **Client's Rights**

1. You have the right to a confidential relationship with your counselor. (See exceptions to confidentiality under "Confidentiality Statement" on page 3.)
2. You have the right to know the content of your records. Upon your written request your counselor may provide you either with a copy of your complete record or a summary of their content.
3. Upon the written request of involved clients your counselor may release any part of your records, to the person you specify. Your counselor will tell you when you make your request whether or not he/she thinks releasing that information to the specified agency or person would be in your best interest.
4. You have the right to ask questions about any of the procedures used in your course of therapy.
5. You, or your counselor, have the right to terminate therapy at any time without any financial, legal, or moral obligations other than those you have already incurred. The following conditions may be reasons for termination:
  - When therapy is no longer beneficial to you.
  - When another professional would better serve you. Your counselor will provide you with other professional referrals.
  - When you have not paid for the last two sessions, unless special arrangements have been made between you and your counselor.
  - When you have failed to show up for your last two therapy sessions.

## Consent for Treatment

I authorize my counselor to administer psychotherapeutic examinations, diagnostic procedures, and/or treatment during the course of my care.

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.

**I have read and understand the above statements about “The Therapy Process,” “Client’s Rights,” and “Consent for Treatment.”**

_____ Name of Client (Print)	_____ Signature of Client	_____ Date
_____ Name of Client (Print)	_____ Signature of Client	_____ Date
_____ Name of Parent/Guardian (Print)	_____ Signature of Parent/Guardian	_____ Date

## Confidentiality Statement

All information revealed by a client during the course of therapy will be kept confidential and will not be revealed to any agency or other person without the client’s written permission. Under certain legally defined situations your therapist is required to reveal information you tell him/her during the course of your therapy with your written consent.

Confidentiality of client information will not be maintained under the following conditions:

1. The therapist has a reasonable suspicion of child abuse. Child abuse is defined as:
  - Physical
  - Sexual
  - Neglect
  - Endangerment - In California child endangerment includes any incidents of Domestic Violence (DV) occurring when children are anywhere in the home or within the vicinity of the DV. The law considers exposing a child to DV “endangers the person or health of a child” and produces “mental suffering” for the child.  
All suspected abuse will be reported to the appropriate authorities.
2. The therapist has knowledge of elder abuse or dependent adult abuse. All knowledge of abuse will be reported to the appropriate authorities.
3. The client threatens suicide, physical harm to self, or appears to be gravely disabled. The therapist will inform client’s support system or report to appropriate authorities to provide safety for the client. (See “Duty to Warn” below.)
4. The therapist has information that his/her client has threatened homicide or other physical harm to another person. The therapist is required by law to warn the intended victim and notify the appropriate law enforcement agencies.

If you are being seen in couples/family therapy, your therapist may have a “no secrets policy” please ask your therapist if this applicable in your situation.

## Duty to Warn

Confidentiality and privileged communication remain rights of all clients according to state law. However, courts have held that if an individual intends to harm him/herself or is gravely disabled, it is the counselor's duty to warn appropriate individuals of such intentions. Those warned may include a variety of individuals and is up to the counselor's discretion. Such individuals may include the following:

- Family members, caregivers, and/or friends of the client
- Law enforcement officials
- Local psychiatric emergency team members

Before breaching confidentiality the counselor will take all possible steps to first share that intention with the client. Every effort will be made to prevent any such breach of confidentiality.

**I have read the above "Confidentiality Statement" and "Duty to Warn" and I understand my counselor's legal and ethical responsibility to make such decisions where necessary.**

_____ Name of Client (Print)	_____ Signature of Client	_____ Date
_____ Name of Client (Print)	_____ Signature of Client	_____ Date
_____ Name of Parent/Guardian (Print)	_____ Signature of Parent/Guardian	_____ Date

## Office Policies

**Cancellation:** Since an appointment reserves time specifically for you, a minimum of 72 hours notice is required for rescheduling or cancellation of a scheduled appointment. The full fee will be charged for missed sessions without such notification. Most insurance companies do not reimburse for sessions missed.

**Office Hours:** Office hours are from 9 a.m. to 6 p.m. Monday to Friday. If you need to contact your counselor between sessions, please leave a message on your therapist's confidential phone/voice mail. In the event of an emergency please see "Emergency Procedure" below.

**Emergency/Crisis Procedure:** In the event of an emergency please call 911 or go to your nearest emergency room for care. In the event of a crisis please call your therapist's confidential phone/voice mail and he/she will call you back as soon as possible.

**Telephone Time:** After 10 minutes of telephone time, you will be charged your regular fee on a prorated basis.

**Sessions Greater Than 50 Minutes:** Sessions that go beyond fifty minutes will be prorated to the nearest quarter hour, unless you have made prior arrangements with your counselor.

**Waiting Room Policy:** Children under 12 years of age are not to be left unattended in the waiting room. Books and games are there for your enjoyment.

## Financial Agreement

You are expected to pay for services at the time they are rendered unless other arrangements have been made. Please notify your counselor if any problem arises regarding your ability to make timely payment.

Client's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

I agree to enter a therapeutic relationship with \_\_\_\_\_  
Counselor's Name/Title

The agreed upon fee per session is \$ \_\_\_\_\_.

I understand that I will make payment in cash or by check, made out to Break Thru Counseling, at the time of the therapy appointment, unless other arrangements have been made with my counselor. I understand that I can leave therapy at any time and that I have no financial, legal or moral obligation to complete the treatment. I agree to pay for completed therapy sessions, sessions I miss without providing a 72 hour notice, and/or telephone time as outlined in the above "Office Policies." Break Thru Counseling Center does not accept debit or credit cards.

Upon entering a therapeutic relationship with a Break Thru counselor I understand that my financial information will become privy to the accountant for Break Thru Counseling Center. All financial information will be held in strictest confidence by the accountant. This may include information that I carry on my personal check such as; name, address, phone number, fee/payment amount, and financial institution.

## Insurance Reimbursement

Clients who carry insurance benefits that reimburse for mental health treatment should remember that therapeutic services are rendered and charged to the client and not to the insurance company. If you plan to use insurance reimbursements, upon your request, your therapist will provide you with a super bill for you to file with your insurance company.

I understand that by using insurance benefits I authorize my counselor, if necessary, to disclose required information to my insurance company to assist in processing the claim. Required information may be as follows: assessment, diagnosis, treatment plan, treatment costs, dates of service, type of therapy, etc.

## Acknowledgment of Receipt of Privacy Practices

I have received a copy of Break Thru Counseling Center's "Notice of Privacy Practices" with an effective date of April 14, 2003. (National Provider Identifier Number 1871781211.)

**I have read, understand, and agree to the above "Office Policies," "Financial Agreement," and "Insurance Reimbursement." I acknowledge receipt of privacy practices.**

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Name of Client (Print)                      Signature of Client                      Date

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Name of Client (Print)                      Signature of Client                      Date

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Name of Parent/Guardian (Print)                      Signature of Parent/Guardian                      Date