

Therapy Agreement

Sydney Isley, M.A., LMFT #88861
DBA Chino Valley Therapist

Welcome to my practice

This document contains important information about my professional services and business policies and how they may affect you. Please read it carefully and make note of any questions you want to discuss with me. Once you sign this document, it will become a binding agreement between us and will provide your consent for us to begin therapy.

Therapy is a unique and highly individual experience with the outcome determined by the effort and motivation you bring to work towards the process. It can result in benefits to you and can potentially help in your ability to detect, challenge, and change beliefs and attitudes that create, maintain, and worsen feelings of depression, anxiety, panic, anger, frustration, etc. Therapy also has the potential to help you gain new or deeper understanding about your issues and learn new ways of coping with and solving them.

However, there is no guarantee that therapy will yield positive or intended results. Because feelings will be explored, you may feel a range of emotions that can be intense and uncomfortable at times. During therapy some of your assumptions, perceptions, or behaviors may be challenged, which can cause you to feel upset, angry, depressed, uncomfortable, confused, or disappointed. I encourage you to explore those feelings during our sessions, as they are part of the therapeutic process. In the attempt to resolve issues that originally brought you to therapy, unintended changes in your personal and interpersonal relationships may result.

Our therapeutic relationship is strictly voluntary. At any time during our work together, you have the right to decide to end treatment. If you are thinking about ending therapy, I encourage you to discuss it with me, and if you wish, I will be glad to provide you with the names of other mental health providers. During therapy, if I assess that I am unable or ineffective in helping you reach your therapeutic goals, I will discuss this with you, and if appropriate, terminate treatment. I will provide you with referrals and assist you in the transition to a new therapist if you so desire.

Meetings

Each session lasts 45-50 minutes and will begin at the time agreed with you. Typically, therapy sessions take place on a weekly basis, at a mutually agreed time.

Cancellations and Rescheduling

If you need to cancel or reschedule a meeting, please notify me by telephoning my office at least 24 hours in advance of our scheduled meeting or you will be responsible for full payment for the session. (No emails or texts please). Keep in mind that insurance companies do not reimburse you for a missed session or a late cancellation.

Fees

Payment of the agreed upon session fee must be made in full at the beginning of each session in unless other arrangements have been made. Please bring your check ready (made payable to Sydney Isley, LMFT) so that we can maximize your therapy time. If you would like to charge your credit card, the Electronic Payment Authorization form needs to be completed by you. Your session fee may be increased annually. In the event of any fee changes, you will be notified at least 30 days prior to such changes.

If you wish to seek reimbursement for my services from your health insurance company, please contact your insurance company to find out their limits of coverage for mental health services. Once you have done so, you will submit the claims to the insurance company. I must charge my full fee when you submit claims to the insurance companies. Insurance companies vary greatly in their coverage of psychotherapy services, so check your policy to make sure that services provided by a licensed Marriage & Family Therapist are covered as an out-of-network provider.

Additional Fees

You will be assessed an additional fee for extended sessions and telephone conversations that exceed ten minutes. You will also be assessed an additional fee for writing reports or evaluations authorized or requested by you, for copying your file, and for providing court or deposition testimony.

Contacting Me

You may contact me at [909-907-4236](tel:909-907-4236), Monday through Thursday until 9pm. I will try my best to reach you within 24 hours of your phone call. On weekends or holidays, I will only return calls in the cases of emergency, otherwise I will return calls on Monday or the day after the holiday. Phone calls are generally limited to 10 minutes, beyond this time you will be charged at a prorated amount of my usual fee. **If you cannot reach me by phone and you feel that you may hurt yourself or someone else go the nearest emergency room or call 911!**

Email and Texting Usage

By nature, therapy is confidential. You can have the confidence that your insights, vulnerable experiences, and feelings will not be repeated outside the therapeutic relationship established. By nature, email correspondence is NOT confidential. Though Internet security measures can be effective, it is never 100% seal proof. My policy regarding email usage is as follows: Email correspondence with me is NOT secure. Email correspondence is NOT a substitute for person-to-person therapeutic treatment, unless discussed with me in advance and in person. Email correspondence will not play a part in your therapy. I will not respond to your emails in general. Anything stated in an email from you will be discussed in session, and in session only. Email correspondence is NOT to be used in the case of an emergency to contact me. I will terminate treatment if email usage is or becomes inappropriate.

Emergencies

If you are experiencing a life-threatening emergency and need to talk to someone immediately, you can call 911, the Suicide Prevention Hotline at (800) 273-TALK (8255), the police, or your local hospital emergency room and ask for the psychologist or psychiatrist on call.

Confidentiality

In general, what you share with me in session is confidential and privileged unless a mandated or permitted exception to confidentiality exists under California or federal laws.

For instance, I am mandated by law to report threats of harm to self or another, to report suspected child, elder, or dependent adult abuse, or if a court order compels the disclosure of your mental health information.

On the other hand, I am permitted by law to discuss your case with supervisors, peer counselors, or other health care professionals to provide service to you, although my preference is to get a written authorization from you to do so.

When working with minors, confidentiality will be kept unless there is a concern that the child is in danger of harming himself, herself or others. In such cases, and time permitting, the parent(s) will be notified of my concern and if possibly, I will have discussed the matter with the minor and have done my best to handle any objections he/she may have. During treatment, I will provide parents with only general information about the progress of treatment and the attendance of scheduled sessions.

Agreement

I have read this information fully and completely, I have discussed any questions I had about the information, and I understand the information. I acknowledge that it is my choice to participate in psychotherapy (or have my child participate). I realize that the outcome of therapy depends upon my personal investment in the therapy process. I have familiarized myself with the fees and charges for services provided by Sydney Isley, M.A. Licensed Marriage and Family Therapist, and I understand and agree that the therapeutic services rendered will be charged to me and not to any third-party payer. I acknowledge responsibility for payment of these services.

Consent for Treatment and Limits of Liability

Sydney Isley, M.A., LMFT #88861

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Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any “cures” cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect

If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to harm another person, the therapist is

required to warn the possible victim and notify legal authorities, if the victim is reasonably identifiable. However, if you disclose a plan to harm another person, the therapist is required to notify legal authorities if the victim is foreseeable.

Abuse of Children and Vulnerable Adults

If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e., the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances

Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers

Insurance companies and other third-party payers are given information that they request regarding services to the clients. The type of information that may be requested includes types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

Agreement

I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

Cancellation Policy
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If you are unable to attend an appointment, I request that you provide at least 24 hours advanced notice to our office. Since I am unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency. In that case, if I am able to place you in another spot in that same calendar week, no cancellation fee will be assessed. For cancellations made with less than 24-hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be charged in full on your next visit to my office. I appreciate your help in keeping the office schedule running timely and efficiently.

Client Email/Texting Informed Consent Form

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Risks of Using Email/Texting

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

1. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
2. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
3. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
4. Employers and on-line services have a right to inspect emails sent through their company systems.
5. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
6. Email and texts can be used as evidence in court.
7. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the Use of Email and Texts

Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

1. Email and texting are not appropriate for urgent or emergency situations. Provider cannot guarantee that any email and/or text will be read and responded to within any particular period of time.
2. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
3. All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
4. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
5. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
6. Provider is not liable for breaches of confidentiality caused by the client or any third party.
7. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by email or text.

COVID-19 Informed Consent

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DBA Chino Valley Therapist

You are not required to receive psychotherapy in person. By coming to the office, you assume the risk of exposure to COVID-19 (or any other health risk). If you are concerned about possible risks to your health, consult with your physician before attending in person meetings.

I will respect your decision should you at any time choose to return to Telehealth services. If at any time it becomes unsafe due to a resurgence of COVID-19 or other health reason, I may require we resume Telehealth sessions. If I determine a return to Telehealth services is necessary, I will attempt to share that decision with you as soon as practicable.

By receiving services in person, you will be mindful of the risks to yourself, your therapist, and your family members. I request the following from you:

1. You will only attend in person sessions if you are free of COVID-19 symptoms. I am happy to provide you with Telehealth services if you are feeling unwell.
2. You will adhere to the public health orders addressing requirements for facial coverings and social distancing to the extent they exist.
3. You will wash your hands and/or use hand sanitizer prior to entering my office.
4. If you touch your face during session, it is recommended that you immediately wash or sanitize your hands.
5. If you are working in a job that exposes you to individuals who may be infected, I request that you please let me know. I do not recommend attending in person sessions if you are exposed to anyone who may be infected with COVID-19.
6. If you or a member of your immediate household tests positive for COVID-19, you should not attend in person sessions. You agree that if this is the case, you will inform me (and my staff) immediately so that we may resume Telehealth sessions.

There are certain circumstances under which I may be required to notify health authorities that you have been in the office. This typically would only occur if someone who had been seen in my office were to test positive for COVID-19. If this situation arises, and in accordance with applicable privacy laws, I will provide the minimum information necessary for the health authorities to perform their duties.

Telehealth Consent

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Telehealth/Online Therapy

California law recognizes Telehealth as an acceptable format for the delivery of health care and behavioral health services. In California, "Telehealth" is defined as a method to deliver health care services using information and communication technologies to facilitate consultation, diagnosis, treatment and care management while the patient and provider are at two different locations.

Telehealth offers clients increased flexibility when an in-person appointment is not possible. Therapy is conducted using a secure HIPAA-compliant audio/video platform. You will need access to a computer with audio/video capabilities and a reliable internet connection. It is required that you conduct your Telehealth sessions from a private and secure location. It is understood that when communicating by internet or other electronic means, disruptions in service or other technical difficulties can occur from time to time. If this occurs during the course of our session, please contact me at [\(909\) 907-4236](tel:9099074236).

My cancelation policy remains the same for online sessions: a 24-hour notice is required with full fee due for missed appointments. I will maintain a credit or debit card on file for any fees associated with treatment (i.e. copays, missed sessions, or session fees) unless we agree upon different arrangements.

Privacy and Confidentiality Considerations

Although the internet provides the appearance of anonymity and privacy in counseling, privacy is more of an issue online than in face-to-face sessions. The client is responsible for understanding the potential risks of confidentiality being breached through unencrypted email, lack of password protection, or leaving information on a public access computer in a library or internet café. Confidentiality could be breached in transit by hackers or internet service providers or at either end by others with access to the client's account or computer. Clients accessing the internet from public locations should consider the visibility of their screen to people around them. The client is responsible for securing their own computer hardware, internet access, physical location, email, and passwords. Please use additional safeguards such as creating secure passwords, maintaining a high level of security on your wireless internet and closing all windows/programs associated with the online session. The client should be aware of the proximity of others and understand the possibility exists that our conversations may be overheard. Take steps to ensure your physical privacy when in session. Please keep in mind that, just as in face-to-face counseling, privileged communication does not apply when someone else is in the room. The counselor has a right to privacy. Recording any portion of the sessions and/or posting any portion of the sessions on internet platforms such but not limited to Instagram, Facebook or YouTube is strictly forbidden.

Lack of Non-verbal Cues and Asynchronous Communication

Misunderstandings are possible with online communication due to restricted non-verbal cues and asynchronous communication (or "lag time" between responses). Be patient with the online therapy process and be sure to clarify information if you think I have not fully understood you. Please also be patient with me as I periodically ask for clarification due to these circumstances.

Additional Limitations

There is a chance that your insurance company may not cover this format of treatment. In this case, the fee for service lies solely on the client. Online therapy is not a substitute for medication under the care of a psychiatrist or doctor. Online therapy is not appropriate for all clients. When should I seek traditional mental health treatment rather than online therapy?

1. If you are having thoughts of harming yourself (e.g. suicidal thoughts) or harming someone else (e.g. violent thoughts towards others) or psychotic symptoms, **please call 911, 1-800-273-TALK (National Suicide Prevention Lifeline), or a local hospital emergency room. A list of area hospitals is provided at the end of this document.**
2. If you are in an abusive or violent relationship.
3. If you have been seriously depressed.
4. If you have serious substance use dependence.

Acknowledgement and Acceptance

I understand and agree that:

1. I give my consent to engage in Telehealth with Sydney Isley, LMFT, as a part of my psychotherapy.
2. I understand that Telehealth includes the practice of health care consultation, diagnosis, delivery, diagnosis, treatment, transfer of medical data, and education using interactive audio, video, or data communications.
3. I have read and understand the privacy risks and limitations of Telehealth stated above.
4. I understand that there are other risks and consequences from Telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that:
 - a. the transmission of my medical information could be disrupted or distorted by technical failures
 - b. the transmission of my medical information could be interrupted or intercepted by unauthorized persons
 - c. my medical information could be overheard by other persons in my local vicinity or environment
5. I understand that I have the following rights with respect to Telehealth:
 - a. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any benefits to which I would otherwise be entitled.
 - b. The laws that protect the confidentiality of my medical information also apply to Telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
6. Telehealth is not a substitute for medication under the care of a psychiatrist or doctor.
7. Telehealth is not appropriate if I am experiencing a crisis or having suicidal or homicidal thoughts. In case of emergency situations, I will contact the resources listed here.
8. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.
9. I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

Emergency Contacts

If you have an emergency, feel suicidal or homicidal please:

1. **Call 911**
2. **Call 1-800-273-TALK (National Suicide Prevention Lifeline)**
3. **Go to the nearest Hospital Emergency Room**

Emergency Psychological Services

Canyon Ridge Hospital

5353 G. Street,
Chino CA. 91710
909-590-3700

Aurora Charter Oak

1161 E. Covina Blvd
Covina, CA 91724
626-966-1632

Emergency Room Locations

Pomona Valley Hospital

1798 North Garey Avenue
Pomona, CA 91767
909-865-9500

Aurora Charter Oak

1161 E. Covina Blvd.
Covina, CA 91724
626-966-1632

Chino Valley Medical Center

5451 Walnut Ave
Chino, CA 91710
(909) 464-8600

San Dimas Community Hospital

1350 W Covina Blvd
San Dimas, CA 91773
(909) 599-6811

Montclair Hospital Medical Center

5000 San Bernardino St
Montclair, CA 91763
(909) 625-5411

Corona Regional Medical Center

800 S Main St
Corona, CA 92882
(951) 737-4343

San Antonio Regional Hospital

999 San Bernardino Rd
Upland, CA 91786
(909) 985-2811

Riverside Community Hospital

4445 Magnolia Ave
Riverside, CA 92501
(951) 788-3000

Kaiser Permanente Ontario

2295 S Vineyard Ave
Ontario, CA 91761
(833) 574-2273

Agreement and Signature
Sydney Isley, M.A., LMFT #88861
DBA Chino Valley Therapist

I acknowledge that I have read and understand the information provided in this document in its entirety, all of my questions have been answered to my satisfaction and I agree to the terms and conditions contained within. I acknowledge that I am the client or the legal representative of the client, and I agree that my drawn or generated signature is a legally binding equivalent to my handwritten signature.

Signature of Client:

Date: