Sheila Marshall, MA, LMFT, PPS
818 N. Mountain Ave Ste 219
Upland, California 91786
909-437-0765

WELCOMES YOU

We find that communication with our clients regarding our financial policy assists us in providing the best service to you. We therefore have answered some of the most commonly asked questions for you. If you have any additional questions, please ask us. We are happy to assist you.

FULL PAYMENT IS DUE PRIOR TO THE TIME THAT SERVICES ARE RENDERED

Fees for services were agreed upon prior to commencement of session for the rate of $_____. Payment is expected at the time services are rendered. We accept cash and personal checks as payment for services and are due prior to each session.

_____(Initial Here)

REGARDING INSURANCE

Services are provided on a CASH ONLY basis. Please verify with your insurance carrier prior to the commencement of services regarding any related services and reimbursement procedures as this office/staff are not responsible for any insurance issues. A "Super Bill" will be provided as a receipt upon request when made prior to services being rendered.

REGARDING EMPLOYEE ASSISTANCE

Services are provided on a CASH ONLY basis. Please verify with your insurance carrier prior to the commencement of services regarding any related services and reimbursement procedures as this office/staff are not responsible for any insurance issues.

ADDRESS CHANGE

Please advise us if your address, telephone number, email or place of employment changes during the course of your treatment.

_____(Initial Here)

EMERGENCY AFTER HOUR CARE

If you have an emergency after hours please call our office number at (909) 437-0765 or and leave a message we will be paged promptly and respond to your emergency. If you are in need of support during none office hours, please be aware prompt response to your message maybe delayed due to holiday and or none operating hours. Remember to leave your telephone number at the time of each call. If at any time, you are unable to reach our offices by phone and you are in an emergency situation please call 911 or go to the nearest emergency room.

COMMUNICATION IN BETWEEN SCHEDULED SESSIONS

There is limited use of communication in between scheduled session when needed to cancel or reschedule appointment date(s) or time via telephone, text or email. Due to efforts of maintaining confidentiality, there will be no use of these modes of communication for any treatment related issues. If specific issues arise between scheduled appointment times, please feel free to schedule an additional session for assistance.

PLEASE READ EACH OF THE FOLOWING SECTIONS AND INITIAL EACH SECTION AFTER YOU READ IT, THEN SIGN THE FINAL SECTION WHERE APPROPRIATE.

TREAMENT PHILOSOPHY-BRIEF THERAPY EXPLANATION

We believe in a whole-person wellness approach based on goal orientated solution focused and resiliency model treatment goal-oriented, problem focused treatment, along with the use of applied behavior analysis perspective. This means that a treatment goal or several goals are established after a thorough assessment and will be monitored for progress toward goal(s). All treatment is then planned with the goal in mind and progress is made toward accomplishment of that goal in a time-effective manner. You will take an active role in setting and achieving your treatment goals and monitoring progress. Homework and referral to resources and related supports is necessary for you to experience a successful outcome. Your commitment to this treatment approach is necessary for you to experience a successful outcome. If you ever have any questions about the nature of the treatment or anything else about your case, please don't hesitate to ask. You may throughout treatment be asked to comply with treatment recommendations and/or homework. These objectives are designed for treatment success. Compliance to these recommendations is necessary.

_____(Initial Here)

CONFIDENTIALITY STATEMENT

I understand that all the information between provider of treatment and patient is held in strict confidentiality, unless;

1. The patient authorizes a release of information with his/her signature.
2. The patient presents a physical danger to themselves.

3. If mental condition becomes an issue in a lawsuit
4. Injuries resulting from spousal abuse or other assaultive conduct.
5. The patient presents a danger to others
6. Child or Elder neglect or abuse is suspected.

I understand in the latter three cases; the therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken.
_____(Initial Here)
All written and spoken material from any and all sessions are confidential unless you give written permission to release all or part of the information to a specified person, persons, or agency or unless any of the six items occur. _____(Initial Here)

RELEASE OF INFORMATION

I authorize release of information in the course of consultation or professional communication with the professional referral source and other health care providers and institutions for purposes of diagnosis and treatment. I further authorize the release of information for claims, certifications/case management, quality improvement and other purposes related to the benefits of my health plan. _____(Initial Here)

APPEALS AND GRIEVANCES

I acknowledge my right to request reconsideration, (an appeal), in the case that outpatient visits are denied by my insurance certification. I understand that I would request an Appeal through my therapist and that I risk nothing in exercising this right.
_____(Initial Here)

I understand that I may submit a complaint or grievance to my provider or the group director at any time to register a complaint about my care. If I am not satisfied with the response I receive, I can send my complaint directly to my insurance carrier
_____.(Initial Here)

EMERGENCY ACCESS

Therapists are available after hours to handle emergency, (life threatening), situations. By calling the main office number and following the directions for emergency paging, you may speak to a therapist on-call by telephone. It is always recommended to call your PCP and/or visit your urgent care or emergency room whenever there are medical complications. _____(Initial Here)

CANCELLATIONS/MISSED APPOINTMENTS

Scheduled appointments are reserved especially for you. If an appointment is missed or cancelled with less than 24 hours' notification, you will be responsible for 100% of the full session rate. Repeated "No Show" appointments could result in reassessment process and related fees and or up to cancellation of services for a future date, the loss of reserved appointment day and time may result. _____(Initial Here)

CONSENT FOR TREATMENT

I authorize and request that my therapist carry out psychological examinations, treatment and/or diagnostic procedures, which now and during the course of my care are advisable. I understand that while my course of therapy is designed to be helpful, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, anger, etc. Please be aware that this is a normal response to talking about unresolved life experiences and will be worked on between you and your therapist.

_____(Initial Here)

If a patient is a child or dependant of the beneficiary, then the legal guardian/representative on the patient should complete the following:

☐ I legally authorize Sheila Marshall, MS, LMFT to deliver mental health care services,

_____ _____

Signature of Patient or Legal Guardian/Representative Date

_____

Printed Name of Patient