Healing Steps Family Therapy, LLC

Stephen M. Stepanovich MS, LMFT
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INFORMED CONSENT AND OFFICE POLICY STATEMENT

I am a Licensed Marriage and Family Therapist in the State of Nevada. I provide psychotherapy to individuals, including children and adolescents and to families and couples. Marriage and Family Therapists provide care to persons with mental and emotional difficulties of varying intensity and resulting from physical disease, emotional stress, grief, bereavement, life stage changes, family dysfunction, and other traumas. Please take a few minutes to read this information about therapy and the therapeutic process. If you have any questions, please ask at any time. Thank you. **Stephen M. Stepanovich MS, LMFT**

TREATMENT: Treatment begins following an initial assessment. The first several sessions are used to gather additional information to develop an appropriate treatment plan, including how therapy should be delivered, i.e. individual, family, couples, or group sessions. This plan is formulated according to the nature and intensity of your presenting problems. The major goal of therapy is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively.

You are expected to play an active role in your treatment, including working with me to outline your treatment goals and to assess your progress. You may be asked to complete questionnaires or to do homework assignments. Your progress in therapy depends much more on what you do between sessions than what happens in your sessions.

If you and/or I believe that a referral to another professional would be appropriate during the course of our treatment, you will be given referrals for other community agencies and/or private mental health practitioners who may better meet your needs. Treatment is most often terminated by mutual agreement. You may discontinue treatment at any time by notifying me.

I do not conduct assessments or provide therapy for children with pending custody proceedings.

APPOINTMENTS: My office hours are by appointment. Appointments are usually scheduled for 50 minutes. Clients are generally seen weekly or more/less frequently as acuity and circumstances dictate. You may call **702-743-4497** to schedule, reschedule, or cancel an appointment.

CANCELLATIONS AND MISSED APPOINTMENTS:

I, _____ understand that missed or late-cancelled appointments interfere with my treatment and that of other clients who might have been seen at that time.

I agree to the following:

I will attend all scheduled sessions. If I arrive 15 or more minutes late, I may be asked to reschedule and be charged the late cancel fee. If I cannot attend a scheduled session, I will cancel or reschedule the appointment within a 24-hour period.

There is a $100.00 late-cancel fee for any appointment that
I do not cancel by 24 hours of your scheduled appointment.
There is a $100.00 no-show fee for any missed appointment or group session.
I understand that phone calls/text reminders are a courtesy provided by Healing Steps Family Therapy, LLC. If I do not receive a phone call/text reminder, I am still responsible for keeping my appointment and late cancel/no show fees apply.

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Fees are due prior to beginning of a session.

I acknowledge that failing or late-cancelling two consecutive appointments in a row will result in termination of services and I will lose my appointment time. All outstanding late cancel or fail fees must be paid at that time of rescheduled appointment.

Termination of care will end the responsibility of Healing Steps Family Therapy, LLC to see me as a patient. I understand it will then be my responsibility to find another mental health provider to continue my care and that Healing Steps Family Therapy, LLC will work with me to facilitate this transfer of care.

FEES/INSURANCE: The fee for a 45-50-minute individual session is **$150.00**. The Fee for a 45-50-minute couples/family session is **$200.00**. You are 100% responsible for the cost of your psychotherapy. Payment is due at the time of each session, or in the case of telephone consultations, at the next scheduled session, unless other arrangements have been made.
Insurances I accept: Medicaid FFS, United Health, Cigna. All clients regardless of insurance or cash rates are required to fill out a credit card authorization form, this will be used in the event that a canceled appointment is made with less than 24-hour notice. I do not charge a late fee if the appointment is rescheduled for the following week.

Sliding scale rates are offered on a case-by-case basis.

CONFIDENTIALITY: I maintain a record of all evaluation and treatment sessions. This information is confidential. Under Nevada State Law, you have the right to access the information in your medical records. Information about your treatment cannot be shared with anyone (attorneys, physicians, family members, etc.) without your written consent. You may be asked to sign a Release of Information form so that I can exchange information with designated individuals. The limits of confidentiality, and the circumstances when it may/must be breached, are as follows:

- Potential danger/harm to self or others
- Suspected or known child or elder abuse/neglect
- By court order, due to litigation in which a (ex) client is involved
- Filing of insurance claims, insurance audits, case reviews or appeals, etc.
- Breach of Contract (small claims court)
- In natural disasters whereby, protected records may become exposed
- When otherwise required by law

RISKS/BENEFITS: Therapy has been demonstrated to help many individuals. It is most effective when you follow through with any homework assignments or other activities that you and I agree might be helpful. One of the primary risks of therapy is that the process may include discussing problems or events that may evoke unpleasant feelings or memories. If this occurs, please inform me immediately so that the feelings or memories can be addressed in a timely, supportive manner.

EMERGENCIES: In the event of a psychiatric emergency occurring during normal business hours, you should call me and indicate the nature of the emergency. A session will be scheduled as soon as possible if needed. If I am not available due to illness or scheduled vacation, I will provide the name and telephone number of a clinical professional that can provide emergency assistance to you. If you have an emergency that occurs after regular business hours, you should call 911, any psychiatric facility that provides 24-hour crisis assistance or the nearest emergency room. A list of these numbers will be given to you upon request. If you are unable to reach me, you may call your primary care physician or local emergency room.

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THE PATRIOT ACT: *According to Section 215 (e) of the Patriot Act: A person (psychotherapist) who, in good faith, produces tangible things under an order pursuant to this section shall not be liable to any other person for such production. Such production shall not be deemed to constitute a waiver of any privilege in any other proceeding or context.* In other words: I am not required to provide this information to anyone other than the original person seeking the information one time only. I am not authorized to divulge this disclosure, in the event this occurs.

CLIENT: My signature below indicates that I have read and understood the nature and limits of the services provided. I agree to participate voluntarily in therapy services and will aid in the formation and completion of a treatment plan.

MINOR CLIENT: I affirm that I am the legal guardian of _____. I give permission for my child to participate in therapy.

_____ _____
Client signature Date

_____ _____
Client signature Date

_____ _____
Client signature Date

_____ _____
Therapist signature Date