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AGREEMENTS FOR COUNSELING / PSYCHOTHERAPY WITHIN CALIFORNIA

PLEASE INITIAL BOXES TO INDICATE YOU HAVE READ THOSE ITEMS IN PARTICULAR

APPOINTMENTS

1. **Time:** Following our initial consultation, we will set an agreed upon time for your appointments that will be reserved exclusively for you on a regular basis, unless other arrangements are made. If you feel you need additional sessions beyond your regular appointment, please ask. I will make every effort to schedule extra time for you.

2. **Cancellations:** Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in my schedule that could have been filled by another client. As such, if you cannot keep a scheduled appointment, please provide at least 24-hour notification at 818-971-7175 or by email to drj@drjjaffe.com. CANCELLATIONS WITH LESS THAN 24-HOUR NOTICE OR "NO-SHOWS" MAY BE CHARGED THE FULL FEE. Insurance companies will not cover missed appointments; you are responsible for full payment. **In event of late cancellation or missed appointment, you are hereby authorizing Dr. Jaffe to charge your credit card for the fee.**

3. **Session Length:** Unless otherwise arranged, individual counseling sessions are 50 minutes long; child sessions are 30 minutes; couple or family sessions are at least 75-90 minutes long (couple session length will be discussed at first session). Longer sessions are charged for the additional time, pro rata. Your session will begin and end on time. If I am late in starting, you will still receive your full time allotment. Please BRING UP IMPORTANT ISSUES EARLY IN THE HOUR, rather than waiting until the last minutes of your session.

LEGAL/ETHICAL GUIDELINES

1. **Confidentiality**: Both the fact and content of our sessions is confidential and will not be released to a third party without written consent from you, except where required or permitted by law.

☐ **Exceptions to confidentiality** (by law) **include:** the exchange of information necessary for insurance billing; certain court matters; potential danger to self or others; and suspected child, elder, or dependent-adult abuse.

☐ **Couples**: *Confidentiality in couple counseling is held by the unit, not by either individual*: if a legal situation occurs in the future, no records or information will be released to either party without written consent of the other party.

☐ **Adolescents**: In order to encourage open sharing of concerns, confidential discussions with kids age 12 or older will be shared with parents only if life-threatening. Parents will be informed of general issues being discussed. Teens are encouraged to share content of sessions with parents whenever possible.

2. **Substance Use:** The use of substances is contrary to productive work in therapy. If you arrive for your appointment intoxicated or high, the session may be terminated and you will be billed for the time.

3. **Therapist/Client Relationship:** During the counseling process, therapists do not engage in social activities with clients, and UNDER NO CIRCUMSTANCES are expressions of these feelings in a sexual manner either professionally ethical or therapeutically appropriate. If you have previously experienced this type of therapeutic boundary violation and would like to discuss it, I can help you understand what occurred and decide what, if anything, to do about it.

4. **Social Media and Electronic Communications**: As you are aware, electronic communications cannot be guaranteed to be 100% secure. Therefore, I will engage in brief email communications for scheduling or for other specific reasons, but I do not participate in lengthy electronic conversations or email therapy. By extension of the ethical guidelines that prohibit social activities between therapist and client, I do not "friend" clients on social media sites.

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TELEPHONE CONTACT

1. **Messages:** Occasionally, you may need to communicate with me between sessions. Email is usually the best way to reach me. If I am not immediately available, please leave a message on my voicemail pager 818.971.7175. *Please do not go into extensive details and be sure to include times/phone numbers where you can be reached*. I will return your call as soon as I can. *I am not a 24-hour crisis line. If you cannot reach me, and if your safety is involved, please call 911*.

2. **Fees:** There is, of course, no fee for brief phone conversations; however, if extensive consultation is needed and we are unable to schedule a face-to face appointment (for example, in an emergency), you will be charged in 10 minute segments at an individual counseling fee.

FEES AND INSURANCE

NOTE: **$10 deduction if paid by Zelle** to DrJ@DrJJaffe.com

1. **Fee Schedule** *(payable at each session, unless otherwise arranged):*

Individual Adult/Adolescent: Counseling/Psychotherapy/Consulting	50 min.	$225.00
Child: Counseling/Psychotherapy	30 min.	135.00
Extended Session: Individual/Couple/Family Therapy	90 min.	395.00
Phone or Other Professional Consultation	per 10 min.	50.00

2. **For services provided online**: I am aware that Dr. Jaelline Jaffe practices psychotherapy as a California Licensed Marriage and Family Therapist. I agree to consult with Dr. Jaffe either on Zoom, VSee.com, or other HIPAA-compliant platform. I agree that online services are paid in advance by credit card (VISA, MC, Discover, HSA, or debit cards) or Zelle. Unless arranged otherwise, payment in full is due **at the beginning** of each session. I will receive a **$10 deduction in fee if paid by Zelle** to DrJ@DrJJaffe.com. Credit card statement will show payment to **Therapy Partner**.

3. **Insurance:** I understand that Dr. Jaffe does not directly take insurance but provides a "superbill" if California residents wish to submit to their PPO insurance company for possible partial reimbursement for an "out of network" service provider. I will check with my insurance company to determine coverage for reimbursement. Unless arranged otherwise, I will pay my fees, and will receive a monthly statement to submit with my claim form to my insurance company. I agree that I am ultimately responsible for all fees. I acknowledge that I have the option to seek an "in network" therapist at a lower fee established by my insurance company.

4. **Medicare**: I am aware that Dr. Jaffe is an Opted-Out provider, not contracted with Medicare. I understand that Medicare will not reimburse for the cost of services with Dr. Jaffe, and that, if I am a Medicare recipient, as of January 1, 2024 I will need to enter into a private contract with Dr. Jaffe to receive therapy services.

5. **NSA and GFE:** As of 1/1/22, the Federal No Surprises Act went into effect. The purpose is to prevent unexpected charges to clients. There is a requirement to provide a Good Faith Estimate of fees and estimated number of sessions over a given period of time. As example, 3 months of weekly sessions would be 12 x the applicable fee above, or other agreed upon fee.

INFORMED CONSENT

I understand that in the event of present danger to self or others *(or under certain circumstances, if child abuse occurred in the past),* the law requires that psychotherapists seek assistance outside of the counseling setting. I understand that counseling sessions with adolescents may include confidential information that will be shared with parents ONLY if life-threatening.

I understand and accept the guidelines and policies contained in this agreement. I understand the fees and agree that I am responsible for payment. I hereby consent to counseling/psychotherapy under the above stated conditions. My signature also confirms I have received a copy of this agreement.

Signature _____ Date _____

If for minor, Parent/Guardian Signature _____ Date _____