Informed Consent

Information About Your Therapist

I am a **Licensed Marriage and Family Therapist**. At an appropriate time, I will discuss my professional background with you and provide you with information regarding my experience, education, interests, and professional orientation. Please ask questions at any time about my background and experience.

Information About This Practice

The name of this practice is:	**Abran Aviles-Scott, LMFT**
The individual therapist who operates this practice is:	**Abran (aka Abraham) A. Aviles-Scott**
License Type, License Number:	**LMFT #113688**
City of Concord Business License:	**#5022539**

Notice to Clients

The **Board of Behavioral Sciences** receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists. You may contact the board online at www.bbs.ca.gov or by calling **1-916-574-7830**.

Fees and Insurance

The fee for service is **$150** per individual therapy session.
The fee for service is **$200** per conjoint (marital/couples/family) therapy session.
I do not currently provide group therapy sessions.
Please ask if you wish to discuss a written agreement that specifies a sliding scale fee, as appropriate.

Individual and conjoint (marital/family) sessions are approximately 50 minutes in length.

Fees, including copays, are payable at the time that services are rendered. I accept cash, check, American Express, Discover, MasterCard, Visa, PayPal, Apple Pay, and Venmo. Please ask if you wish to discuss a written agreement that specifies an alternative payment procedure, as appropriate.

Please inform me if you wish to utilize health insurance to pay for services. I am a contracted provider with **Carelon Behavioral Health** (formerly Beacon Health Options), **CuraLinc EAP, Kaiser (requires authorization), and Optum (including UnitedHealthCare, UMR, and Sutter Select)**.

If for some reason you find that you are unable to continue paying for your therapy, please inform me. I will help you consider any options that may be available to you at that time.

Insurance Claim Release of Information and Assignment of Benefits

If you use health insurance to pay for services, by signing this Informed Consent you authorize the release of any medical or other information necessary to process insurance claims, and you authorize payment of medical benefits to me as your provider of behavioral health services.

Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment.

If you participate in marital/couples/family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that I utilize a "no secrets" policy when conducting marital/couples/family therapy.** This means that if you participate in marital/couples/family therapy, I am permitted to use information obtained in an individual session that you may have had with me, when working with other members of your family. Please feel free to ask about my "no secrets" policy and how it may apply to you.

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child, dependent adult or elder abuse. Therapists may also be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself.

Minors and Confidentiality

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, in the exercise of my professional judgment, I may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. **I require 24 hours' notice to cancel or reschedule an appointment. If you do not provide adequate notice, you are responsible for payment for the missed session.** Your insurance company will not pay for missed or cancelled sessions.

Therapist Availability/Emergencies

You are welcome to phone me between sessions. However, as a general rule, it is my belief that important issues are better addressed within regularly scheduled sessions.

You may leave a message for me at any time on my confidential voicemail. If you wish me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during my normal workdays within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by my voicemail. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call.

You should be aware that your therapist is generally available to return phone calls within approximately 24 hours.

Your therapist is NOT able to return phone calls after 8:00pm.

Your therapist is NOT available to return phone calls on Sundays and major holidays.

If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail message.

In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

You should also be aware of the following 24-hour resources that are available in the local community to assist individuals who are in crisis:

National Suicide Prevention Lifeline: Call or text **988**, chat online **988lifeline.org**
Contra Costa Crisis Center (Mental or Emotional Services): **1-888-678-7277**
Contra Costa Crisis Center (Suicide or Grief Counseling): **1-800-833-2900**
Homeless Hotline: **1-800-808-6444**
Calli House Youth Shelter: **1-800-610-9400**
Stand Against Domestic Violence: **1-888-215-5555**
Community Violence Solutions: **1-925-798-7273**
LGBTQ Counseling and Service: **1-925-692-2056**
Concord Medical Center/Hospital: **1-925-682-8200**
Other: **Dial 211** or **Text HOPE to 20121** to reach a crisis counselor and receive referrals

Therapist Communications

I may need to communicate with you by telephone or other means. Please indicate your preference by checking one or more of the choices listed below. Please be sure to inform me if you do not wish to be contacted at a particular time or place, or by a particular means.

☐ My therapist may call my home phone number: ____
☐ My therapist may call my cell phone number: ____
☐ My therapist may call my work phone number: ____
☐ My therapist may text my cell phone number: ____
☐ My therapist may send a message to my e-mail address: ____________________________________
☐ My therapist may send mail to my home address:

☐ My therapist may send mail to my work address:

Sensitive, clinical information is to be discussed over the phone or in-person as deemed appropriate by the therapist. For appropriate e-mail or text communication, I will respond to your e-mail or text within 24 hours. Potential risks of using electronic communication may include but are not limited to: inadvertent sending of an e-mail or text containing confidential information to the wrong recipient; theft or loss of the computer, laptop, or mobile device storing confidential information; and interception by an unauthorized third party through an unsecured network. E-mail messages may contain viruses or other defects and it is your responsibility to ensure that it is virus-free. In addition, e-mail or text communication may become part of the clinical record. You may be charged for time the therapist spends reading and responding e-mail or text messages.

About the Therapy Process

It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

I will work with you to develop an effective treatment plan. Over the course of therapy, I will attempt to evaluate whether the therapy provided is beneficial to you. Your feedback and input are an important part of this process. It is my goal to assist you in effectively addressing your problems and concerns. However, due to the varying nature and severity of problems and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. I will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Your signature indicates that you have read this agreement for services carefully and understand its contents.

Please ask me to address any questions or concerns that you have about this information before you sign.

Name of Patient ____

Signature ____

Date ____