Tabatha Stewart, Psy.D.
6235 N. Fresno Ave, Ste. 101
Fresno CA 93710
CA PSY21346
559-492-9061

Policies and Procedures

About My Fees

Usual and customary fees are $110.00 for an individual, 50-minute counseling session unless something else is agreed upon. Should a session last more than the usual 50 minutes, fees will be adjusted accordingly. Phone consultations that last longer than 15 minutes are subject to half the usual and customary fee. *If my customary fee is a financial burden for you, please discuss it with Dr. Stewart and she may be able to negotiate a lower fee with you.*

Payment or co-pay is to be made at the conclusion of each session and all checks need to be made payable to: ***Tabatha Stewart. Please note that there will be a $25.00 fee assessed for any returned check.***

I understand that my fee or co-pay will be $_____for each individual 50-minute counseling session. Couples and family sessions are $140 per 90-minute session; group sessions are $50 per 90-minute session. The excess portions of sessions that extend beyond 45 minutes will be charged in 15-minute increments. Should a telephone contact with you last more than 15 minutes then you will be charged a telephone consultation fee in 15-minute increments at the rate the caller would be charged for an office visit.

Assessment fees are kept on a separate fee schedule. It is very important that you pay the agreed upon fee/co-pay prior to leaving the office after **each individual or group session, in the form of cash or check. If you find it inconvenient to write several checks per month, it is acceptable to pay for several sessions in advance. Fees that are unpaid, or that appear likely to be unpaid, will be discussed with you individually. Accounts are considered delinquent after two sessions are unpaid. At this point, if payment arrangements have not been made, routine appointments will cease until the situation is addressed. If you are having financial troubles that may affect your ability to pay for therapy, please let me know and/or ask for a confidential application for alternative fee arrangements. **Please initial _____**

I will be participating in: Individual _____ Couples_____ DBT Skills Class _____
Family _____ Group _____

Client Commitment to Services

Dr. Stewart is committed to providing you with affordable and professional counseling services. To assist us with our efforts, we ask that you read and sign the following agreement:

*I will make every effort to come for each counseling appointment. If it is necessary to cancel an appointment, I understand that this should be done at **least 24 hours in advance**. Should I fail to notify the counselor and miss an appointment, I understand that the usual fee will be assessed and that it will be my responsibility to pay for the missed session. I also understand that insurance will not cover missed sessions.*

X_____ _____
Signature of client or parent/guardian *Date*

Statement of Confidentiality

A. **Confidentiality:** Under California law, a counselor cannot guarantee confidentiality under the following circumstances:

1. There is suspected or witnessed child abuse or a belief that a child may be in imminent danger of abuse/maltreatment
2. There is suspected or witnessed elder abuse or a belief that an elderly person may be in imminent danger of abuse/maltreatment
3. There is suspected or witness abuse of a disabled person or a belief that a disabled person may be in danger of abuse/maltreatment
4. There is a threat of suicide / homicide, in which case the counselor may contact the appropriate authorities who can help prevent harm
5. In response to a properly issued subpoena from the court or order from a presiding judge.

B. **Except as noted in A above,** no information regarding a client shall be released without the prior written consent of the client or in the case of a minor, the written consent of the minor's parent/legal guardian.

C. Confidentiality is a particularly important consideration where group work is concerned. Group work is based on mutual trust, and violations of that trust can be detrimental to the group as a whole. These issues will be discussed within group frequently.

D. Please read the **HIPPA Privacy Policy** and initial that you have read it. _____**initial**

E. I do work with a medical biller and she may have limited contact with you or with information such as your address, phone number, payment/insurance information.

Emergencies

I have a voice messaging system that can be accessed only by me. It will be checked frequently when I cannot answer the phone personally. I usually return calls within 24 hours.
If you have an urgent need and it's not life threatening you may:

1. Call the office number at 559-492-9061
2. Be sure to ***leave your name and telephone number*** on your message.

If you have a life threatening emergency, feel suicidal, or homicidal please call:
911 for emergency help, or go to any emergency room for immediate care. Please notify this therapist that you had an emergency.

I understand these emergency policies. _____**please initial**

Any suspected violations of counselor ethics may be reported in writing to the following governing agencies:
California Board of Psychology
1422 Howe Avenue, Suite 22
Sacramento, CA 95825
(866)503-3221

I have read & understand the limits to confidentiality _____ **(initial here)**

Disclosure Statement & Consent for Treatment

Please be aware that the therapeutic process may involve personal awareness that may be emotionally painful, may cause heightened emotions, may cause anxiety, tension or stress and may cause some disruption or turmoil in your life as well as the lives of your significant others due to the subject matter being disclosed.
Counseling/therapy also has the potential to provide emotional support and stability for any family member involved in therapy. Further, it may relieve anxiety and create a safe environment for children or family members who are distressed. Finally, counseling/therapy has the potential for creating positive life changes in the form of long term solutions to difficulties, and creating better communication.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I am aware that I may stop my treatment with this therapist at any time. The only thing I will be responsible for is paying for the services I have already received. I also understand that it is in my best interest to discuss termination with this therapist prior to ending treatment so that if referrals are needed they may be provided. I am aware that I must this give this therapist 24-hour notice to cancel a scheduled appointment, otherwise I will be charged for the missed appointment.

I have read and understand all the above statements (**session fees**, **client commitment**, **limits to confidentiality** & **the disclosure statement**) and I voluntarily consent to treatment.

Signature of self/parent/legal guardian: _____Date: _____

Signature of witness: _____Date: _____