TREATMENT AGREEMENT

1. APPOINTMENTS: When I set an appointment with you, that time is yours and yours alone. The counseling sessions last 50 minutes. I will do my best to be punctual for your appointment unless I have an emergency call. If I am late for the appointment, I will either extend your session (if that works for you and there is no one scheduled after you), or refund 50% your co-pay / counseling fee for that session – whichever you prefer. I ask that you be punctual as well. If you are late, for any reason, you will only receive the remainder of your scheduled time. This is necessary so I can see following clients at their scheduled times. You will, however, be required to pay the full fee.

2. MISSED APPOINTMENTS / LATE CANCELLATIONS: Since scheduling an appointment involves the reservation of time specially set aside for you, a minimum of 24-hour advance notice is required to cancel. You will be charged the full fee I would otherwise get paid by you and / or by your insurance company (in this case, $ _____) for a session missed without such notice. Messages may be left on my voicemail, (310) 916-9294, which will accurately record the date and time you called. Please note that most insurance companies do not reimburse you for missed sessions. At my discretion, a waiver of the fee may be provided for late cancellations caused by certain emergencies. If I cancel the appointment with less than 24 hours notice, you won't have to pay the co-pay / counseling fee for your next appointment.

3. INSURANCE: I accept several insurance plans. If your plan is not among those I accept, I require full payment of the agreed upon fee at the time of service, and you may bill your insurance directly. If you should choose to go this route, be sure to ask for a receipt of payment. In giving you a receipt, I am making no guarantees that your insurance will reimburse you.

3. COUNSELING FEES: Counseling fees are set prior to your first appointment. The fee is:
_____ (if no insurance is used)
_____ (co-pay, if insurance is to be billed).
Payment is expected at the time of service unless other contractual arrangements have been made. Fees are to be paid before the beginning of your session.

4. TELEPHONE COMMUNICATION: Phone calls are primarily for scheduling appointments; however, I am available for short consultations not to exceed 10 minutes. For extended calls over 10 minutes, you will be charged according to the prorated hourly fee. In a psychiatric emergency, please call 911, or go to your nearest Hospital Emergency Room and ask for help.

5. RETURNED CHECKS: A penalty fee of $20.00 will be assessed on all checks

returned by the bank for any reason. Re-payment of the returned check must be made by cash, cashier's check, or money order only.

6. UNPAID BALANCES: Payment must be made within 30 days of a missed session or a late charge of $20.00 will be assessed. Any accounts with a past due balance of 60 days or more will be handed over to the collection agency, and will incur a $50.00 processing fee. If your account has an unpaid balance at any time, it may be necessary to suspend therapy sessions until the account is paid.

7. CHILDREN: I do not provide care for your children while you are in a counseling session and I am not responsible for any child that is left unsupervised. Young children can be disruptive to other clients, so I ask that you do not bring children to the office unless they are receiving counseling themselves. Should you leave children unattended in the waiting room, I will request that you leave your counseling session to attend to them.

I am dedicated to you and your counseling needs and I appreciate your cooperation in these matters. By signing this Treatment Agreement, I agree that I am bound by this Agreement, and its terms. I further acknowledge that I am personally responsible for all financial obligations incurred.

Any dispute, claim or controversy arising out of or relating to this Agreement or the breach, termination, enforcement, interpretation or validity thereof, including the determination of the scope or applicability of this agreement to arbitrate, shall be determined by arbitration in Los Angeles California before a randomly selected arbitrator on the panel of ADR Services, Inc., or such other arbitration services as the parties may mutually agree. The arbitration shall be administered by ADR Services, Inc. pursuant to its Arbitration Rules and Procedures. Judgment on the Award may be entered in any court having jurisdiction. This clause shall not preclude parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction.

The prevailing party in any dispute, claim or controversy arising out of or relating to this Agreement or the breach, termination, enforcement, interpretation or validity thereof shall be entitled to an award of reasonable attorney's fees pursuant to Civil Code §1717.

Signature:_____ Date:_____

Client (please print name here: _)

Signature:_____ Date:_____

Edina Kishonthy, M.S., LMFT

For billing purposes, please provide your mailing address, incl. city, state and zip:

LIMITS OF CONFIDENTIALITY

Edina Kishonthy, MFT

1. ABOUT CONFIDENTIALITY:

Everything that happens in therapy is strictly confidential and protected under the law. Your therapist cannot discuss anything about your therapy, or even identify that you are a client, unless you give your written permission. There are some instances in which a therapist is required to break confidentiality under the law. These include:

- If you intend to harm another person, I am legally required to warn the authorities and the person you intend to harm and/or his/her family.
- If you pose a life-threatening danger to yourself, I have an ethical duty to take action to protect you, which may include warning the authorities and/or your family members.
- If you disclose that you or someone you know has been, or is, involved in child abuse, elder abuse, or abuse of a disabled person (between the ages of 18 and 64), I am legally required to make a report to the appropriate authorities.
- If your therapy costs are covered or partially covered by insurance, the insurance company will require, at a minimum, a diagnosis and the dates of service. Many insurance companies also require a written progress report and treatment plan. When you sign your insurance claim form, you are waiving your right to confidentiality and granting them access to your records.
- If you become involved in legal matters that involve issues of your medical or mental health, you may be giving up some of your rights to confidentiality. In such a case, your medical records (which include mental health/therapy records) may be subpoenaed. Questions regarding the limits of confidentiality under those circumstances should be discussed with your attorney.

2. CONSULTATIONS:

I regularly consult with a team of licensed therapists in order to provide the best possible service to my clients. Therefore, I reserve the right to consult and discuss pertinent information within this context. If your case is discussed, no personal information will be used that might identify you to the other therapists.

3. CONFIDENTIALITY IN COUPLES OR FAMILY THERAPY – "NO SECRETS POLICY"

When I work with a couple or a family, I consider that couple or family my "patient" as one entity. During the course of my work with a couple or a family, I may see one of the spouses, one or two siblings, one parent, one child, etc. separately for one or more sessions. If you are involved in one or more such sessions with me, please understand that while generally these sessions are confidential toward third parties (with,, of course the same limits as I previously described)),, I may need to share information learned in an individual session with the rest of the family or the other

partner in the couple,, if I am to effectively serve your relationship as one entity.. I will use my best judgment as to whether, when, and to what extent I will make disclosures, and will also, if appropriate, first give the concerned person the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely do not want to be shared with your partner or anyone else in your family, you might want to consult with an individual therapist who can treat you individually.

I have read and understand the limits of confidentiality as described above, and I agree that my therapy will be conducted within these safeguards and exceptions.

_____

Patient Name (please print)

_____ _____

Signature of Patient (or authorized representative) Date