# INFORMED CONSENT

SCOPE OF PRACTICE:

I am a Licensed Marriage and Family Therapist in the State of California. My scope of practice involves treating individuals, couples and families who are working through relational issues.

LIMITS OF CONFIDENTIALITY:

All shared information will be kept confidential except for those discussions mandated by law to report. Those mandated reporting situations are limited to the following:

When the client(s) present a danger to themselves
When the client(s) present a danger to others.
Where child, elder, or dependent abuse is suspected.

PAYMENT POLICY:

All payments are due at the time of session by cash, checks or VENMO @KarenLKlecknerLMFT.

If your EAP/Insurance company pays all or part of your session, you will be responsible for any reimbursements not allowed by them. Outstanding balances are due at the next session or within 2 weeks of the original billing invoice, whichever occurs first.

Rates: Initial Assessment $190.00 Individual $175.00

In the event your Insurance/ EAP Company provides limited sessions and/or authorization time frames, you will be responsible for tracking allowed sessions.

You will be liable for any bank charges due to checks that are returned because of insufficient funds or closed accounts. Any other types of fees incurred in processing your payments will also apply.

CANCELLATION POLICY:

You will be charged my full fee for any missed sessions, or if cancelled within **48 hours** prior to the appointment. Monday appointments require 1 business day for cancellation, i.e. Friday.

Rates: Initial Assessment $190.00 Individual $175.00

If you have insurance, you will be responsible for my full session fee, *not just the co-pay portion*. EAP/Insurance companies do not reimburse for "No Shows".

NO SECRETS POLICY:

When working with couples or families together, no secrets will be kept between the therapist and the client.

INSURANCE COMPANY REQUIREMENTS:

I authorize my mental health benefits to be paid directly to Karen L. Kleckner, M.A., L.M.F.T. Agreeing to the HIPAA regulations, I permit the release of medical billing data related to my claim. I have been offered and read the HIPAA Notice of Privacy Practices (Forms page of my website). Please contact your insurance company or EAP if further information is required.

There is an administrative processing fee at my hourly rate for release of any documentation. I do not testify for court proceedings.

I agree to psychotherapy through Telehealth/Zoom Yes ___ No ___

I have read the above information, agree to and understand the terms.

Client ***SIGNATURE*** (Please do not type name) Date

Karen L. Kleckner, M.A., L.M.F.T. Date