

Kristin Mills, MA  
Licensed Marriage and Family Therapist  
License Number MFC36444  
Phone/fax: (707) 527-6168

## **AGREEMENT FOR SERVICE / INFORMED CONSENT**

### **Introduction**

This agreement is intended to provide you with important information regarding the practices, policies and procedures of Kristin Mills, and to clarify the terms of the professional therapeutic relationship between us. Please discuss any concerns regarding the contents of this Agreement prior to signing it.

### **Risks and Benefits of Therapy**

Psychotherapy is a process in which many issues, events, experiences and memories are discussed for the purpose of creating positive change so you can experience your life more fully. It provides an opportunity to more deeply understand yourself, as well as any problems or difficulties you may be experiencing. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may require substantial effort on your part, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times when I will challenge your perceptions and assumptions, and offer different perspectives. The issues you present may result in unintended outcomes, including changes in personal relationships. You should be aware that any decision on the status of your personal relationships is your responsibility.

During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Please address with me any concerns you have regarding your progress in therapy.

### **Fee and Fee Arrangements**

My usual fee for service is \$140 per 50 to 60 minute session. I reserve the right to periodically adjust my fee and will notify you in advance of any such adjustment. Payment is expected at the time services are rendered.

### **Cancellation Policy**

There will be a \$70 fee for cancellations made later than 24 hours before your appointment. Please note that the fee applies even when the cancellation is due to illness or other unforeseen circumstances that are no fault of your own. Cancellation notice must be delivered to my voice mail or text message at (707) 527-6168.

### **Confidentiality**

The information you disclose is confidential and will not be released to any third party without your written authorization, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.

- A. **Confidentiality and Couples Therapy**: As your therapist, I will not hold the secrets of an individual member of a couple. If clinically appropriate, I may choose to disclose such information and or support the spouse/partner in doing so.
- B. **Confidentiality and Minors**: Psychotherapy can only be effective if there is a trusting and confidential relationship between a therapist and patient. As such, a parent/guardian will typically not be privy to detailed discussions between your minor child and myself. However, parents/guardians can expect to be kept up-to-date as to progress in therapy and they will be informed in the event I have any serious concerns regarding the minor's safety or well being.

### **Professional Consultation**

Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information.

### **Patient Litigation**

To protect the integrity of your therapy experience, I will not voluntarily participate in any litigation or custody dispute. I will generally not write or sign letters, reports, declarations, or affidavits to be used in legal matters. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such appearance at the hourly rate of \$195.00.

### **Psychotherapist-Patient Privilege**

The information you disclose, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between a therapist and patient in the eyes of the law. Typically, the patient is the holder of the psychotherapist-patient privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-patient privilege on your behalf unless instructed, in writing, to do otherwise by you or your representative. Please be aware that you might be waiving the psychotherapist-patient privilege if you make your mental or emotional state an issue in a legal proceeding. Please address any concerns you might have regarding the psychotherapist-patient privilege with your attorney.

### **Therapist Availability**

My office is equipped with a confidential voicemail system that allows you to leave a message at any time. I will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. In the event that you are feeling unsafe or require immediate medical or psychiatric assistance, you should call 911, go to the nearest emergency room, or call the Sonoma County Psychiatric Crisis Clinic at 576-8181.

## Acknowledgement

By signing below, you acknowledge that you have reviewed and fully understood the terms and conditions of the attached Agreement for Service/Informed Consent.

By signing below, you also acknowledge that you are financially responsible to Kristin Mills, MFT for all charges, including unpaid charges by your insurance company or any third-party payer.

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\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian if Patient is a Minor

\_\_\_\_\_  
Date

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Address:

\_\_\_\_\_  
\_\_\_\_\_

Phone Numbers: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred method of communication: \_\_\_\_\_

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