



OAK CREEK RELATIONAL COUNSELING CENTER CLIENT INFORMED CONSENT

Under the supervision of Steve Polin, LMFT #7861, Director of OCRCC, services at Oak Creek Relational Counseling Center (OCRCC) are performed by registered Associate Marriage and Family Therapists (AMFT), Associate Professional Clinical Counselors (APCC) and Trainees. Associates generally leave the agency after receiving their licenses. At this point, if you wish to continue working with your therapist, you can continue with them at their new setting or you can choose to be referred to another therapist at the Center. Trainees at times may wish to record their sessions for training/educational purposes. By signing below, you are agreeing to be audio/video recorded.

1. Fees

Fees are _____ per 50 minute session. You and your counselor will set your fee at the first session. The fee is due at each session unless otherwise agreed upon with your counselor. We take the following forms of payment Cash, Visa, MC, American Express, Venmo, Check or Zelle (925-383-9421).

2. Cancellations

Clients are expected to attend all scheduled appointments and will be charged fees for missed appointments. If you cancel within 24 hours of the appointment, the full fee will need to be paid.

3. Communication

Your therapist will give you his or her confidential voice mail number during the initial session. Please use that number for messages. If for some reason you cannot reach your therapist that way, please call the center

4. Confidentiality

Any and all information shared between you and your therapist is confidential and will only be shared under the following conditions.

1. Therapists share session information/video/audio with their supervisors and OCRCC clinical staff for the purposes of training/education.



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2. You authorize the release of information in writing for the purposes of consultation.
3. Therapists are required by law to report child, elder or adult dependent abuse to the appropriate agency.
4. Therapists are required to intervene appropriately with threats of serious harm to yourself or others. This could require reporting to the police or appropriate agency.
5. A court of law subpoenas information for a legal proceeding.

5. Courts

"Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature. I agree that neither I nor my attorney nor anyone else acting on my behalf will call on (_____) to become a witness to testify in court, communicate with child custody evaluator/s, or any other proceeding, or request a disclosure of the "psychotherapy records."

6. Your Rights

You have the right to receive a "Good Faith Estimate" explaining how much your medical and mental health care will cost. Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services. You can ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service. If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises



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7. Notice to Clients

Supervisors Steve Polin (LMFT) and Alison Urdan (LMFT) receive and respond to concerns or complaints about any of the associates or trainees at Oak Creek. They can be reached at 510-282-5109 (Steve) and 510-220-0990 (Alison).

The Board of Behavioral Sciences receives and responds to complaints regarding services provided by individuals licensed and registered by the board. If you have a complaint and are unsure if your practitioner is licensed or registered, please contact the Board of Behavioral Sciences at 916-574-7830 for assistance or utilize the board's online license verification feature by visiting www.bbs.ca.gov

By signing this, my signature indicates that I have read this statement and consent to treatment. You have a right to request and receive a copy of this Consent for Treatment form.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____