**Oksana Heicklen**
Licensed Marriage and Family Therapist
License # MFC 43656
760-805-4740

**Date:**_____

# INFORMATION AND POLICIES

Please carefully review and sign this form as confirmation that you understand and agree to the terms of this therapeutic relationship. Feel free to ask for clarification on any of the items.

**Confidentiality:** All communication between client and therapist will remain confidential unless you request specific information be discussed with outside parties (for example, family members, other health professionals, school staff, etc.). In such cases, written authorization to release the information will be requested from you. I am mandated by law to break this confidentiality in the following circumstances:

- If I am ordered by the court to testify or release records.
- If you are a victim or perpetrator of child abuse.
- If you are a victim or perpetrator of elder or dependent adult abuse.
- If you threaten harm to yourself, someone else, or the property of others.

**Minors and Confidentiality:** Communication between therapist and clients who are minors (under the age of 18) is confidential. However, I may discuss treatment progress with parents or guardians in exercise of my professional judgment, with the best interests of the minor in mind.

**Fees:** My fees for services are set using a sliding scale. I always take the client's situation into consideration. Your fee is _____, and will be collected at the beginning of the appointment. I recommend preparing your payment prior to your arrival so that your time is maximized. I do accept some insurance policies. If I am a contracted provider for your insurance company, I will discuss the procedures for billing your insurance. Any insurance that you have is a contract between you and your insurance company. Insurance policies vary greatly. Many of them have a specific deductible per year and varying co-pays. I suggest that you inquire about the specific benefits of your policy by calling your insurance company.

**Your signature below authorizes me to bill your insurance directly on your behalf**. For clients that are paying for sessions privately, you have the option to submit a bill to your insurance company to see if they will reimburse you. Please let me know if you would like me to provide you with a statement at the end of each month for you to send to your insurance company.

**Cancellations: 24 hours notice is required if you need to cancel a session.** Your consistent attendance greatly contributes to a successful outcome. Please notify me at least 24 hours in advance of your appointment for any changes or cancellations, if you don't want to be charged the full session fee. _____ (initials)

**In the event of an emergency, please call 911 to request emergency assistance or go to the nearest hospital.**

*I/we have read this information and agree to these policies. I understand I am financially responsible, whether my insurance company pays or not, for charges incurred by me, and for the full cost of missed appointments or cancellations with less than 24 hours notice. I agree that in the event of non-payment, I will bear the cost of collection should this action be required.*

| Client Name (print) | Client Signature | Date |
|---|---|---|

| Parent/Guardian Name (print) | Parent/Guardian Signature | Date |
|---|---|---|