

**Debra L. Rodriguez Burns, MFT #MFC43583**  
**8723 Sierra College Blvd. Granite Bay, California 95661**  
**Office: (916) 797-8822 Fax: (916) 797-2767**  
**acmepsych.com**

### **Introduction**

Welcome to my private practice. I am a Licensed Marriage and Family Therapist, governed by the Board of Behavioral Sciences. I have been working in the field since I entered my master program in 1996. My focus is working with children, adolescents, families, couples and adults. I use a variety of modalities to assist in the healing and growth process. I look forward to meeting you and discussing your needs, wants and desires.

Please read this document carefully and feel free to ask any questions you may have regarding its contents. This document is intended to provide you with important information about your treatment.

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### **Informed Consent**

While therapy has proved to be beneficial in many cases, it is not a guarantee. Sometimes, during the normal course of therapy, symptoms may increase; issues or behaviors may in fact become worse before they get better. Even if symptoms are alleviated by therapy, it is possible that symptoms may return at a later time. Any such occurrences should be discussed with your therapist immediately. Regular attendance and motivated participation provides the best opportunity for positive outcome(s).

I have read, understood, and agree to the above.

\_\_\_\_\_  
Client initials

\_\_\_\_\_  
Parent initials

\_\_\_\_\_  
Therapist initials

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### **Consent to Treat**

I authorize Debra L. Rodriguez Burns, MFT to provide psychotherapeutic services to \_\_\_\_\_. I understand that it is the therapist's intention to provide us with the services that will assist us in meeting our goals. Partnering together, discussing the specifics of our needs, we will determine the best course of treatment. I understand that my therapist will periodically provide recommendations and feedback regarding progress and invite my participation in the discussion. I understand that we have the right to agree and disagree with my therapist's recommendations.

I have read, understood, and agree to the above.

\_\_\_\_\_  
Client initials

\_\_\_\_\_  
Parent initials

\_\_\_\_\_  
Therapist initials

## Rules of Confidentiality

According to California State Law, all the information regarding therapeutic sessions is confidential between the counselor and the client(s) who are present in the session, **except** for the following:

1. If the counselor has information which leads him/her to **suspect** the following:
  - A. Child Abuse
  - B. Elder Abuse
  - C. The client has intent to harm self or others
  - D. The client is a danger to self, others, or property
  - E. The client is unable to take care of self

In such situations, the counselor is legally obligated to report all information to the proper authorities (CPS, Sheriff's Department, Police, etc.) or to warn the intended victim.

2. If the client(s) sign a written release of information to a particular person or agency.
3. If there is any court subpoenas issued to the counselor.

I have read, understood, and agree to the above.

\_\_\_\_\_  
Client initials

\_\_\_\_\_  
Parent initials

\_\_\_\_\_  
Therapist initials

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## Confidentiality

### Minors:

Communication between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide consent for their child's treatment are often involved in their treatment. Consequently, therapists, exercising their professional judgment, may discuss the treatment progress of the minor patient with the parent/legal guardian. Patients who are minors and their parents are urged to discuss any concerns and/or questions with their therapist.

### No Secrets:

In conjoint sessions (family/marital) your therapist will not disclose confidential information unless each participant in treatment session(s) has given written authorization to release such information. Although, it is important to know that your therapist implements a "no secrets" policy when conducting conjoint sessions. This means that any person(s) participating in a conjoint session, information obtained during previous conjoint sessions and individual sessions, is permitted to be shared. Your therapist is committed to assisting in opening the lines of communication. Please feel free to discuss your concerns or questions about this policy with your therapist.

**Therapist Communication:**

Your therapist may need to contact you by telephone, mail or alternate means. Please indicate your preference by checking one of the choices below. Please notify your therapist if you wish to be contacted at an alternate number or address then listed on the demographics form.

Please check all that apply:

- Phone:    Home    Work      Cell      Fax \_\_\_\_\_  
 Mail:    Home    Work \_\_\_\_\_  
 Other \_\_\_\_\_

I have read, understood, and agree to the above.

\_\_\_\_\_  
Client initials

\_\_\_\_\_  
Parent initials

\_\_\_\_\_  
Therapist initials

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**Therapist Availability/Emergencies**

Telephone consultations are welcome in between therapy sessions, although are kept brief, due to the belief that issues are better addressed during regular scheduled sessions. If an additional session is needed or desired an additional therapy appointment may be scheduled.

You may leave a message for your therapist to return your call on her confidential voicemail. Please leave your name, phone number and brief description of the call. Calls will be returned within 48 hours during normal business days/hours (Monday-Friday, 9-6pm). Your therapist is not available to return calls on Saturdays/Sundays and/or holidays. Messages left during those days will be returned the following week. If you have an urgent need to speak to your therapist, please indicate that on your message and follow the steps provided on your therapist's voicemail. For emergencies, please call 911 to request assistance.

I have read, understood, and agree to the above.

\_\_\_\_\_  
Client initials

\_\_\_\_\_  
Parent initials

\_\_\_\_\_  
Therapist initials

### **Fee Agreement/Cancellation Policy**

I/we agree to pay one hundred twenty five dollars and zero cents (\$125.00) for each individual or conjoint, 50 minute session. Payment in cash, check or credit card is accepted and fees are payable at the time services are rendered. A fee of \$25.00 will be assessed for returned checks. I/we understand that my therapist can change my fee at any time and that at least two weeks notice will be given if an increase occurs.

I/we understand that my therapist does not take insurance at this time, but that my therapist will provide me with a Superbill to submit to my insurance provider. I understand that it is my responsibility to seek out payment from my insurance company and that although my therapist is happy to assist in this process; my therapist is unable to guarantee whether your insurance will provide payment for the services provided to you.

I/we understand that 24 hours notice must be given for every cancellation. I/we understand that I/we will be billed for the full fee of the missed session for any cancellation under 24 hours or for a “no show”.

If you find that you are unable to continue paying for therapy sessions, please inform your therapist immediately. Your therapist will help you to consider any options that may be available to you at that time.

I understand that Debra L. Rodriguez Burns, MFC is an independent contractor and has no business ties to the other therapists working in this office.

I have read, understood, and agree to the above.

\_\_\_\_\_  
Client initials

\_\_\_\_\_  
Parent initials

\_\_\_\_\_  
Therapist initials

## Termination of Therapy

The length and determination of eventual termination of treatment depends on the specifics of your treatment plan and progress you have achieved. Your therapist will discuss and collaborate with you, planning your termination, as completion of your treatment goals approach.

You may discontinue therapy at any time. If you or your therapist determine that you are not benefiting from treatment, either may elect to discuss treatment alternatives. Alternatives may include, among other possibilities, referral, changing treatment plans, or terminating therapy.

If you have any concerns or questions about this information, please feel free to ask your therapist.

I have read, understood, and agree to the above.

\_\_\_\_\_  
Client initials

\_\_\_\_\_  
Parent initials

\_\_\_\_\_  
Therapist initials

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Thank you for taking the time to complete the above information.

By signing below I acknowledge that I have read, understood and agree to the above information.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date