Laurie Nickel Supkoff, LCSW
1329 Howe Avenue, Suite 201
Sacramento, CA 95825
(916) 743-1605

Office Policies & General Information
Agreement for Co-Parent Counseling Services

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are privileged and confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law.

When Disclosure Is Required by Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled.

When Disclosure May be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by me, Laurie Nickel Supkoff, LCSW. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless I am authorized to do so by all adult family members who were part of the treatment.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matter which may be of a confidential nature, you agree that should there be legal proceedings (such as custody disputes, injuries, lawsuits, etc.), neither you (clients) nor your attorneys, nor anyone else acting on your behalf, will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Consultation: I consult regularly with other professionals regarding my clients; however, neither clients' names, nor any other identifying information, are ever mentioned. My client's identity remains completely anonymous and confidentiality is fully maintained.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please leave a voicemail message at (916) 743-1605 and your call will be returned as soon as possible. I check my messages several times each day unless I am out of town. If an emergency arises, please indicate it clearly in your message. If you need to talk to someone right away you may consider calling your family physician.

Initials _____

PAYMENTS, INSURANCE REIMBURSEMENT & RETAINERS: My practice is currently online via Thera-link due to Covid-19 concerns. Payment is due upon logging in for the appointment unless other arrangements have been made. Each 50-minute session will be billed at the rate of $185.00 per session. If your insurance will cover this type of counseling, I will supply you with an insurance billing form that you can submit to your insurance provider for direct reimbursement.

_____Yes, I will need an insurance bill for reimbursement

Clients also agree to pay and maintain a retainer in the amount of $370.00. Retainers can be used to cover costs described in the pertinent sections below. Unused retainers will be refunded to clients at the end of co-parent counseling.

PHONE, EMAILS AND LETTERS: Phone calls requiring more than five (5) minutes and emails including any information other than scheduling an appointment shall cost the client the same hourly rate as a counseling session for the time required to print and read the emails. If a letter is needed and agreed upon by both parents, there will be a minimum charge of $100.00. The cost would increase if the time required extends over 20 minutes. Retainers can be used to cover these costs.

THE PROCESS OF CO-PARENTING COUNSELING: Change happens because a person consciously decides to speak and behavior differently. Growth does not happen without purposeful choice and effort by that individual. Your co-parenting relationship will improve to the degree both parents make the wise choice to apply themselves and make the necessary changes. Only you can determine what you will say and do. Please know that your child(ren) will thrive to the degree their parents provide a tension free environment and peaceful parental exchanges.

Referrals: If in the course of our working together I determine that I cannot assist you to the full degree you are in need of, I will refer you to another professional(s) who would likely be more able to assist you in your efforts to produce change and growth in your life.

Dual Relationships: Therapy never involves sexual or business relationships or any other dual relationship that impairs the therapist's objectivity, clinical judgment, and therapeutic effectiveness or can be exploitative in nature.

CANCELLATION: Appointments are arranged so that we share a consistent, ongoing weekly or biweekly scheduled time together. If your appointment must be canceled, a minimum of **24 hours** prior notice is expected to avoid being charged for that session. If one parent cancels the session in less than 24 hours, that parent will be responsible for the entire cost of the missed session. You will also be charged if you "No Show" for your scheduled time. Retainers can be used to cover these costs.

Initials _____

My Agreement to You: I agree to assist you in gaining awareness and understanding of the obstacles you face, and to help you gain new skills to make healthy choices in your life, however, this in no way guarantees that the changes you would like to have happen will occur.

I have read the above Office Policies and General Information Agreement carefully; I understand them and agree to comply with them.

_____

Client Name (print) Date Signature

Laurie Nickel Supkoff, LCSW _____

Therapist Date Signature