

**Patricia Holden, M.A. L.M.F.T.**  
**Licensed Marriage and Family Therapist**  
**TREATMENT AGREEMENT**

Thank you for contacting me. I offer a range of services for adults and adolescents including brief solution-focused psychotherapy.

I work from my private office in Mill Valley; my **private office** is located at:

275 Miller (ground floor)  
Mill Valley, California 94941<sup>1</sup>

Please do not mail to my office address. My **mailing** address is:

P.O. Box 204  
Tiburon, California 94920

**Assessment & Treatment**

I will provide an assessment of difficulties and available treatment options. For individual adult patients, I use cognitive-behavior therapy in combination with other client-centered techniques. With couples, I use a combination of Gottman techniques and Emotionally Focused Therapy techniques.

It is important for you to know that treatment can be time-consuming and stressful; at times it can bring on strong feelings, like anger, frustration, sadness or anxiety, and may result in changes that were not originally intended (such as divorce or remaining in a relationship you believed you would leave). There is a small risk that the condition may worsen due to treatment. After meeting with me to assess your situation, I would offer, if you like, an estimate of the number of sessions of treatment I recommend. For most patients, this ranges between 10 and 40 sessions. My estimate of the duration of treatment is only an estimate, and no guarantees can be made as to the length of treatment required.

After assessment, I may recommend other options to the treatment that I offer, such as other types of psychotherapy, group, family, or recovery work. Testing and formal evaluation can be helpful in some cases, and if I recommend this to you, I will outline my recommendations and the reasons for it.

You are entitled to ask questions about all aspects of treatment. I will help you secure a consultation with another mental health professional whenever you request it or if I recommend it.

For those under the age of 18, I also provide an assessment prior to treatment. I work with the family and child on treatment goals, which may include, with the parent's permission, liaison with the school or other professionals.

---

<sup>1</sup> Patient acknowledges and understands that Patricia Holden M.A., M.F.T., is a sole proprietor which means that she is in business for herself and that Patricia Holden M.A., M.F.T., is not engaged in a partnership, joint venture, professional corporation, or any other form of business organization with any of the other practitioners in this suite of offices.

## **Patient's Role**

You are expected to play an active role in your treatment, including working with me to outline treatment goals and completing questionnaires at the beginning of the treatment and periodically during treatment to assess progress. You will be asked to complete homework assignments between sessions. If at any point you are unhappy about the progress, process, or outcome of the treatment, please discuss this with me so we can resolve any difficulties and arrive at a treatment plan that better meets your needs.

## **Fees**

- ◆ The fee per 50-minute session is \$110.00 Fees are payable by check or cash at the time of service.
- ◆ Initial assessment sessions are 90-minutes and the fee is \$175.00.

## **Cancellations**

- ◆ You will be charged \$110.00 for missed sessions or those cancelled without 24-hour notice, except in the cases of sudden illness or family emergency (babysitter cancellations are not considered "family emergencies"). Note: Insurance plans will not pay for missed or late-cancelled sessions. If you do not cancel within the 24-hour period and you are a "network" client, then you are responsible for the allowed and usual insurance-paid amount. If I cancel "late", I owe you a free session.

## **Insurance**

Please read the following information carefully as this outlines my billing and claim policy for in-network and EAP insurance patients. Please discuss with me any concerns or questions you have.

I am a network provider for some insurance companies. This means that I have agreed to extend a discount on my regular fee to you based on your plan's eligible services. I will also bill your insurance company for the sessions for which your individual plan indicates it will cover.

Although insurance companies may refer to me as a "preferred provider", I have a very limited role with the insurance company; insurance companies do not inform me of changes or modifications to your eligibility or benefits. I am a sole practitioner trained in clinical psychology; I am not an expert in billing.

Therefore, as a courtesy to patients who wish to use their in-network/EAP insurance benefits:

- ◆ I will check your behavioral health eligibility and benefits before your treatment begins, at the time of intake ONLY. I will bill your insurance company based on the information I receive at your intake from the insurance representative. However, insurance companies do not guarantee coverage or payment until claims are processed. Therefore, the insurance company reserves the right to change what they will cover, regardless of what they may tell me when I check at intake. Frequently, insurance companies do not cover claims or portions of claims even though they have indicated at intake that the benefit is covered.
- ◆ Insurance plans can change without notice. You are responsible for informing me in writing of any changes to your insurance plan.

◆ **If I bill your insurance plan, you must pay your portion of the charges (the co-payment, co-insurance, deductible or any portion of the claim) that the insurance company does not pay.**

◆ Any portion of unpaid claims will be charged to a credit card which you have authorized me to use for this purpose. (A credit card authorization is included). I will provide a written receipt to you.

◆ Should you wish to have your claim re-processed by me, you (or the insured) is ultimately responsible for providing to me all paperwork required by the insurance company, including authorization and treatment plan requests and any other required forms.

◆ If your plan limits the cumulative number of visits allowed to one or more providers, it is your responsibility to make me aware of the number of visits allowed and that you have accumulated, in writing. I am unable to provide extra processing, research, or evaluation of your plan's benefits after my initial intake eligibility request, although I do attempt to check benefits when they renew at the beginning of a calendar year. I must receive a written request from you or your insurance company in order to submit pre-authorizations and/or treatment plans for you. I will not request retroactive pre-authorizations.

In summary, if I am billing your insurance plan, you must pay your portion of the charges (the co-payment or any other charges the insurance company does not pay) and any deductible at the time of the session. While I may submit insurance claims for you, **by signing this form, you are agreeing to be responsible for any portion of the fee not paid by your insurance plan and to authorize me to charge your credit card for any charges not covered by your plan.**

**Please sign the following: by signing you are indicating that you understand all my billing policies and you agree to them.**

"I authorize the release of any information (including treatment plans, summaries and diagnoses) necessary to process insurance or Employee Assistance claims, or to request additional sessions.

I authorize payment of benefits to be made to Patricia Holden M.A., M.F.T. for services provided. I authorize Patricia Holden to charge my credit card for any portion of claims, missed or late cancelled appointments that *are not paid* by my insurance company."

---

Signature (Parent if under 18)

Date

---

Signature (Second Patient)

Date

## Credit Card Authorization Agreement

I, \_\_\_\_\_, authorize Patricia Holden M.A., M.F.T to charge my VISA/ Mastercharge (circle one), account number:

\_\_\_\_\_

Expiration date \_\_\_\_\_ Security Code \_\_\_\_\_

to pay all portion of charges not covered by my insurance plan. The name and billing address for this VISA / Mastercharge (circle one) is:

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

I understand that I am authorizing Patricia Holden to charge my credit card for:

- Any co-payments or co-insurance not paid at time of service.
- Deductible amounts owing with regard to any services that are covered by my member benefit agreement or insurance plan ("My Plan").
- Any services provided to me by Patricia Holden but not covered by My Plan, as a result of my ceasing to be covered by My Plan or if the services provided to me exceed the limit on the number of sessions covered by My Plan.
- Missed or late cancelled appointments.

I understand that it is solely my responsibility to ascertain what services are covered by My Plan.

If I cancel or close this credit account, I will notify Patricia Holden immediately in writing, because she is relying upon this information to provide continuing services to me.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (second patient)

\_\_\_\_\_  
Date

## **Confidentiality**

What you say in therapy, your records, and your attendance are confidential, *except*:

- ◆ When you give written permission to release information.
- ◆ When your records are subpoenaed for legal reasons.
- ◆ When reporting is required or allowed by law (i.e., suspected child abuse/neglect, extreme danger to self, suspected elder abuse, or danger to others).
- ◆ Other exceptions as outlined in my *Notice of Privacy Practices*.

All communications between you and me will be held in strict confidence unless you provide written permission to release information about you or your child's treatment, assessment, or academic planning. If you participate in family or couple's therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in treatment with you provide their written authorization to release. (In addition I will not disclose information communicated privately in my presence, to any other family member without written permission).

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, I in the exercise of my professional judgment may discuss the treatment progress of a minor patient with a parent or caretaker. Please discuss with me any questions or concerns that you have with this process.

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a client presents a serious danger of physical violence to another or when a client is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI Agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

## **Record-Keeping**

I maintain a clinical chart for each patient. Information in the chart can include a description of your condition, your diagnosis, treatment goals, treatment plan and progress in treatment, dates and fees (if applicable) for each session. If you are using your insurance, the company may request to see this information. My informal psychotherapy notes are separate from this information and are generally not accessible to insurance companies, unless required by law.

All records are stored in a locked cabinet and on the computer in my office. The hard drive that includes information from your clinical record is password protected. When your treatment is over, the records are stored for ten years after treatment ends (or whatever is required by law), after which they are destroyed.

### **Electronic Communications**

Email communications are not secure. I will use email to communicate with you regarding non-confidential matters, such as office directions, appointment confirmations, and basic insurance information. Because it is not a secure mode, I do not communicate nor will I respond to confidential information communicated by email. I discourage you from emailing me anything you would not want to be publicly accessible.

### **Communications**

I will need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. **Please be sure to inform me if you do not wish to be contacted at a particular time or place, or by a particular means.**

Please check all that apply. You are giving me permission to:

call me at my home. My phone number is \_\_\_\_\_

call me on my cell phone. My cell phone number is \_\_\_\_\_

call me at work. My work phone number is \_\_\_\_\_

send mail to my home address: \_\_\_\_\_

send mail to me at my work address: \_\_\_\_\_

communicate with me by email. My email address is \_\_\_\_\_

send a fax to me. My fax number is \_\_\_\_\_

send me a monthly receipt for insurance reimbursement (out of network insurance claims only)

### **In An Emergency**

Contact the nearest emergency room or the Marin County Crisis Unit at 415-499-6666 or 911. You may try to reach me on my answering machine, but in case I am not immediately available, please use these contact numbers.

### **Endings**

You may end therapy at any time. A final phone call or session is requested for closure. If you miss a session or discontinue treatment for 4 weeks or more and I do not hear from you, I will try to contact you. If I am unable to reach you, I will assume (unless other arrangements have been made) that you have elected to terminate your treatment and I will close your case. And, if you wish to resume treatment, I will be happy to discuss that option with you at any time.

