Jim Rutherford, M.S.
Licensed Marriage and Family
Therapist LIC #MFC 42435
1425 Broadway # 4
Burlingame, CA 94010

650-599-2255

AGREEMENT FOR SERVICE / INFORMED CONSENT

Introduction

This Agreement is intended to provide you with important information regarding my practices, polices and procedures, and to clarify the terms of the professional therapeutic relationship between the Client and Therapist. Any questions or concerns regarding the contents of this Agreement should be discussed with me prior to signing it.

Risks and Benefits of Therapy

Psychotherapy is a process in which Therapist and Client discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so the client can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties the client may be experiencing. Psychotherapy is a joint effort between Client and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

During the therapeutic process, many Clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. I encourage you to address any concerns you may have regarding your progress in therapy with me.

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice. As such, 1 regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, 1 will not reveal any personally identifying information regarding Clients.

Records and Record Keeping

I may take notes during session, and will also create other notes and records regarding a Client's treatment. These notes constitute clinical and business records, which by law, Therapists are required to maintain. Such records are the sole property of the Therapist. I will not alter normal record keeping processes at the request of any Client. Should Clients request a copy of the records, such a request must be made in writing. I reserve the right, under California law, to provide Client with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as

requested, provide a copy of the record to another treating health care provider. I will maintain Clients' records for ten years following termination of therapy. However, after ten years, Clients' records will be destroyed in a manner that preserves their confidentiality.

Confidentiality

The information disclosed by a Client is confidential and will not be released to any third party without written authorization from Client, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a Client makes a serious threat of violence towards a reasonably identifiable victim, or when a Client is dangerous to him/herself or the person or property of another.

Fee and Arrangements

The usual and customary fee for service is $140.00 per 50-minute session. 1 reserve the right to periodically adjust this fee. Client will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with third-party payers. or by written agreement.

The agreed upon fee for these sessions is ________ .

From time-to-time, I may engage in telephone contact with Clients for purposes other than scheduling sessions. Clients are responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, I may engage in telephone contact with third parties at Client's request and with Client's advance written authorization. Client is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. Clients are expected to pay for services at the time services are rendered. Cash, checks, and money orders are accepted.

Cancellation Policy

Client is responsible for payment of the agreed upon fee for any missed session(s). Client is also responsible for payment of the agreed upon fee for any session(s) for which Client failed to give at least 24 hours notice of cancellation. Cancellation notice should be left on voice mail at 650-599-2255.

Therapist Availability

I can be reached by contacting a confidential voicemail at any time at 650-599-2255. 1 will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. I am unable to provide 24-hour crisis service. In the event that Clients are feeling unsafe or require immediate medical or psychiatric assistance, he/she should call 911 or go to the nearest emergency room.

Termination of Therapy

I reserve the right to terminate therapy at my discretion. Reasons for termination

include, but are not limited to, untimely payment of fees, conflicts of interest, failure to participate in therapy, Client needs are outside of my scope of competence or practice, or Client is not making adequate progress in therapy. Client has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, I will generally recommend that Clients participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both of us an opportunity to reflect on the work that has been done. 1 will also attempt to ensure a smooth transition to another therapist by offering referrals to Client.

Acknowledgement

By signing below, Client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Client has discussed such terms and conditions and all questions have been answered to Client's satisfaction. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy. Moreover, Client agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

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Client Name(s) (please print)

______________________	______________________
Signature of Client / Date	Signature of Client/ Date
______________________	______________________
Signature of Client / Date	Signature of Client/ Date

I understand that I am financially responsible to Therapist for all charges.

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Name of Responsible Party (Please print)