Laini Golden, LCSW BBS License #65008
3416 American River Drive, Suite B / Sacramento, CA 95864
Phone (916) 572-7544 Fax (916) 92-9500

TREATMENT AGREEMENT

This treatment agreement outlines the responsibilities of each person in the therapeutic relationship, the issues of confidentiality, pertinent policies and an overview of treatment.

I. Responsibilities

A. The therapist is responsible for:

1. Utilizing an individually-designed treatment plan based on current research.
2. Being available to discuss your concerns and questions.
3. Providing age-appropriate developmentally sequenced interventions and strategies.

B. The caregiver/client is responsible for:

1. Being on time to all scheduled sessions.
2. Canceling appointments at least 24 hours in advance, or as soon as possible in case of emergency or illness.
3. Staying in the building during your child's appointment (if applicable).
4. Advising the therapist of any change in the patient's life or living environment.

C. The child/adolescent is responsible for being on time to all sessions

II. Policies Pertaining to Clients:

A. No Show Policy (details in attached Client Fees and Appointment Information)

1. After the 1st and 2nd failure to attend a scheduled session without proper notification, (see above) you will be contacted by phone to discuss the problem and the no show policy and/or a letter will be sent to you requesting that you contact the office within 10 days. If you make no contact within 10 days your case may be closed and no further attempts at contact will be made.
2. After a 3rd failure to attend a scheduled session without proper notification, your case may be closed without further contact regardless of the reason. A letter will be mailed informing you of the case closure and appropriate referrals will be offered.

B. Excessive Cancellation Policy - If a total of 3 cancellations are made within a 2-month period, your case may be closed, regardless of the reason. A letter will be mailed informing you of the closing and appropriate referrals will be offered.

C. Late Policy - If you arrive more than 15 minutes late for a scheduled session, you may be seen for the remainder of the scheduled session time. If you decide not to stay, it will be considered a cancellation.

D. Emergencies

1. If you (or your child) engage in behaviors that risks harm to yourself or someone else, call 911 or the Sacramento County Mental Health Treatment Center, Minor Emergency Response Team (MERT) at (916) 732-3637. MERT is located at 2150 Stockton Blvd.
2. If you have an urgent matter between scheduled sessions, please contact the therapist as needed. A confidential voice mail phone will answer your call and your call will be returned as soon as possible, usually within 48 hours. Immediate responses can not be expected.

III. Limits of Confidentiality

Confidentiality will be respected and protected maximally. California State Law, however, identifies specific situations in which confidentiality must be breached by licensed professionals. These situations include a "duty to warn" in case of a reasonable suspicion of child abuse or neglect, elder/dependent adult abuse or neglect, or "danger to self."

A. Duty to Warn - If a client's statements and/or prior history indicate that s/he poses a serious threat of physical harm to another person or group of persons, the therapist has a duty to warn the foreseeable victim(s) of that danger by trying to contact the victims and by informing the police.

B. Child Abuse and Neglect (defined below)

1) A physical injury inflicted by other than accidental means on a child.
2) Child sexual abuse including both sexual assault and sexual exploitation.
3) Willful cruelty or unjustified punishment, including inflicting or permitting unjustifiable physical pain or mental suffering.
4) Unlawful corporal punishment or injury, willfully inflicted, resulting in a traumatic condition.
5) Neglect of a child, whether "severe or general" must also be reported if the perpetrator is a person responsible for the child's welfare.
6) Any of the above types of abuse or neglect occurring in out of home care.

C. Elder/Dependent Adult Abuse/Neglect - Physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment resulting in physical harm, pain or mental suffering.

D. Danger to Self - If a child or family member reports suicidal ideation, attempts suicide, or verbalized a plan to harm him/herself, an appropriate adult and/or institution must be informed to protect the individual from harm.

IV. Other Treatment Issues

A. Payment of Fees and Record Keeping

1) Payment will be agreed upon prior to the start of any treatment. Payment is expected at the time of service provision by cash or check unless otherwise agreed upon by the therapist and client, or payee. (See attached Client Fees and Appointment information for more detail.)
2) Personal information will be maintained in a highly confidential manner. All client information is kept in a locked file cabinet when not in use. Each contact (phone or in person) is recorded in a treatment note and placed in client's record.

B. The Client has the additional following rights:

1) To know this therapist's title, training, experience, and area(s) of special expertise.
2) To know the area in which this therapist is not adequately trained to provide certain services, in which case a referral will be made.
3) To know the probable length of treatment, to review your treatment plan and progress on a regular basis.
4) To to review your file upon request.
5) To know the possible benefits as well as risks of the therapeutic services you receive (e.g., disruptions in your life, treatment may be ineffective, improvement in parenting/relationship with child, etc.)
6) To know that there are alternatives to the services you receive from this therapist.
7) To discontinue services at any time.

I HAVE REVEIWED THE ATTACHED TREATMENT AGREEMENT WITH THIS THERAPIST AND UNDERSTAND THE RESPONSIBILITIES AND LIMITS DESCRIBED.
I ACKNOWLEDGE RECIEPT OF A PHOTOCOPY OF THIS AGREEMENT

By signing below, you acknowldedge reading, understanding, and agreeing to the above terms.

Signature of Client or Parent	Date	Signature of Therapist	Date