Michelle **Sicula, J.D., M.A.**
Marriage and Family Therapist Intern Reg. No. 73257
Supervised by John Wiskind, L.C.S.W. LCS22185

Client Consent for Treatment

The following information is provided to assist you in understanding policies and procedures at my office. Any questions or concerns you may have regarding the contents of this agreement should be discussed prior to signing it. By signing this agreement, you agree and acknowledge that any questions and/or concerns you have regarding the services or this agreement have been answered and resolved to your satisfaction.

I. Qualifications of Clinician

I am a Marriage and Family Therapist Registered Intern, Reg. No. 73257. That means I am not yet licensed as a marriage and family therapist. I am employed and supervised by a licensed clinical social worker, John Wiskind, L.C.S.W., LCS22185. John Wiskind's phone number is 510-292-9090. I regularly discuss treatment and services being provided to clients with my licensed supervisor.

II. Risks and Benefits of Therapy

In psychotherapy therapist and clients discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change. Participating in therapy may result in a number of benefits, such as reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. However, there is no guarantee that therapy will yield the benefits listed above. Progress and success may vary depending upon the particular issues being addressed, as well as many other factors. Psychotherapy is a joint effort between client and therapist.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. It may evoke strong feelings of sadness, anger, fear, etc. The issues presented may result in unintended outcomes, including changes in personal relationships. During the therapeutic process, clients may find that they feel worse before they feel better. This is generally a normal course of events. Any concerns regarding progress/treatment should be addressed with the therapist.

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III. Confidentiality

Your treatment, information revealed by you in therapy, and your records are generally confidential and will not be released to any third party without your written authorization, except where required or permitted by law, as provided in my Notice of Privacy Practices. Exceptions to confidentiality, include, but are not limited to the following:

1. There are certain situations in which I, as a mental health professional, am required by law to reveal information obtained during therapy to other persons or agencies without your permission. These situations include:
    a. If you threaten bodily harm or death to another person, I am required by law to inform the intended victim and appropriate law enforcement agencies.
    b. If you threaten bodily harm or death to yourself, I will inform the appropriate law enforcement agencies and others (such as spouse, friend, or an inpatient psychiatric institution) who could aid in prohibiting you from carrying out your threats.
    c. If you reveal information related to the abuse or neglect of a child, dependent adult, or elderly person, I am required by law to report this to the appropriate authorities.

2. At times therapy will involve the participation of more than one family member and/or significant persons. If we are doing Couples or Family Therapy, I maintain a "no secrets" policy. That means information shared by an individual outside the presence of other participants in the therapy may be shared with other participants in the therapy during subsequent sessions.

3. Under some circumstances, I could be compelled to disclose your confidential records if I am served with a court order for clinical records because you are a party in legal proceedings. If I am served with a court order seeking your records I will make every reasonable effort to notify you prior to disclosing your records so that you may take steps necessary to protect your privacy.

4. As indicated in section I above, I will share information with a licensed supervisor for the purpose of enhancing the effectiveness of the therapy you are receiving.

IV. Fees and Payment

1. An individual therapy session is 50 minutes. A couples therapy session is 50-75 minutes. I typically see clients on a weekly basis; however, we may see each other more than once a week or every other week depending on need. If you are unable to attend your scheduled appointment, you must call 24 hours in advance or you will be charged a late cancellation fee **equivalent to your usual fee for appointments**. I will consider the appointment cancelled if clients arrive more than 15 minutes after the scheduled appointment time.

2. Payment is required at the time of your appointment. If at any point in the course of treatment you are unable to pay your fee, please communicate this to me and fee arrangements may be renegotiated. My standard fee is $90 per fifty-minute hour, $110 for a sixty-minute couples/family therapy session and $135 for seventy-five-minute

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couples/family sessions. I may offer a reduced fee for clients based on financial need. Clients assume a $20.00 penalty fee associated with NSF checks. I typically raise my fee periodically and will give you at least one-month notice of a fee increase.

V. Emergencies, Telephone Calls and E-mail

1. I can often be reached at (510) 457-1246 Monday through Friday 9am to 6pm. Although I can make no guarantee, I strive to return calls within 24 hours. If you are in crisis or are feeling suicidal please call 911 or go to the nearest emergency room.

Each county has a 24 hour support hotline which can be used at anytime. The following are hotline numbers for local counties:

Alameda County: 1.800.309.2131
Contra Costa County: 1.800.833.2900
San Francisco County: 415.355.8300

2. Please be aware that e-mail, text and fax communications can be relatively easy to access by unauthorized people which can compromise your privacy and confidentiality. I do not have e-mail encryption capabilities. For that reason, I do not transmit confidential information about clients via e-mail. E-mail and phone communication are typically reserved for scheduling communications only. I typically respond to e-mail within 48 hours during the work week, unless I am out of town. My email address is: msicula@gmail.com

3. See my website www.MichelleSicula.com for a copy of my Social Media and Technology Policy.

VI. Termination of Therapy

1. Both you and I have the right to terminate services at our discretion. Some examples of reasons that a therapist might terminate therapy include failure of client to comply with treatment recommendations, conflicts of interest, failure of client to participate, client needs are outside of the clinician's scope of competence or practice, or lack of adequate progress. You have the right to decide at any time not to receive therapy from me. If you wish, I will provide you with the names of other qualified professionals whose services you might prefer.

   Upon either party's decision to terminate services, participation in at least one termination sessions may be made. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Attempts will also be made to ensure a smooth transition to other services by offering referrals.

2. If you feel I have done something harmful or unethical and you do not feel comfortable discussing it with me, please do not hesitate to contact my supervisor John Wiskind at 510-292-9090. In addition, you can always contact the Board of Behavioral Science Examiners, which oversees licensing, and they will review the services I have provided.

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Your Informed Consent to Care Acknowledgment

I have provided this information to you in the hope of fully informing you about the policies of my office. By signing below you are acknowledging that you have reviewed and fully understand the terms and conditions of this agreement and that you have discussed any questions. Your signature acknowledges your informed consent for care. I recommend printing a copy of this form for your records.

Client Signature:_____ Date:_____

Client Signature:_____ Date:_____

Address:_____ Phone: _____

Therapist Signature:_____ Date:_____

Michelle Sicula, J.D., M.A.
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