pdbtc

pacific dbt collaborative
6 petaluma blvd. n suite b6 & b12
petaluma, california 94952
pacificdbt.com

Welcome to Pacific DBT Collaborative,

Enclosed are directions and new patient forms to complete and bring with you on your first visit.

Please be advised that charges for therapy are out of network with all insurances. You will be given a super bill at each visit that you may submit to your insurance carrier for reimbursement, providing you have out of network coverage. Please verify with your carrier your type of coverage and whether or not you will need prior authorization before starting treatment.

Patients are responsible for providing a credit card to be kept on file (M/C, VISA, AMEX or Discover) or paying by check at each visit.

Please remember that all group therapy must be paid in full at the beginning of each 4 week session. You may provide a credit card or pay at the first visit by check to the provider.

General Fees
Initial Intake: $200.00
Individual therapy sessions: $140-$180 for 50-minute session (depends on clinician)
Family therapy sessions: $210-$270 for a 90-minute session (depends on clinician)
Group sessions: $70.00 per group session

Pacific DBT Collaborative PAYMENT POLICY

Payment is expected at the time of your visit. Any bills that are 60 days or more past due will be referred to a collection agency. An itemized superbill will be provided to you monthly for your insurance carrier upon request. It is your responsibility to submit to insurance for reimbursement. You must have out of network insurance coverage to receive reimbursement. All of the providers are out of network with all insurance carriers, including MEDICARE.

Appointments must be cancelled at least 48 hours in advance or there will be a charge in the full amount of the scheduled visit. Please ask your individual provider if they have any further cancellation policies in addition to the general office policy.

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For your convenience we accept MASTER CARD – VISA –AMEX - DISCOVER - CASH – CHECK. If you would like to keep a credit card on file to have your visits automatically charged please complete the section below.

I authorize Pacific DBT Collaborative to keep my signature on file and charge my credit card for services rendered. I understand that this authorization is valid until such time that I cancel the authorization through written notice to the office.

Cardholder's name

_____

Address

_____

_____

Acct # _____

Exp Date _____

CVC # _____

Master card Visa AMEX Discover

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Signature of Cardholder _____ Date_____

Authorization for release of medical, psychiatric and billing records (Protected Health Information)

The information covered by this authorization includes all medical, psychiatric and billing information pertaining to your treatment with Pacific DBT Collaborative. The information may be used and/or disclosed by the physicians and staff pertaining to your care.

Please list the names and phone numbers of any private physicians, therapists and/or **family members** that you wish to have authorization to speak with your therapist. Patients over 18 years of age must give permission for their provider to speak to their parents.

_____

_____

_____

_____

If you wish to restrict your private medical information from disclosure to an individual or entity – please list the names below.

_____

_____

This authorization is effective through life unless revoked or terminated by the patient or the patient's legal representative. You may revoke or terminate this authorization by submitting a written revocation to the office. Potential for re-disclosure of information that is disclosed under this authorization may be that it is disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under federal privacy regulations.

Name of Patient _____

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Date of Birth

Signature of Patient _____

Date_____

Signature of parent or guardian if patient is a minor

_____

Informed Consent for Treatment

This is intended to provide you with important information regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents. You are free to ask questions at any time about my experience and professional orientation.

Fees for Services

My fee for service is _____ for a 50-minute session. If we choose to have a longer session, the fee will be adjusted accordingly. I may charge for phone contact between sessions or other tasks that are related to your treatment and I will inform you before charging you a fee for services outside of the therapy hour. I do not take insurance but can provide you with documentation to submit to your insurance company. If you are unable to continue paying for therapy, please inform me and I will help you to consider options that may be available. **Please cancel sessions with 48 hours advanced notice or you will be responsible for payment**. All cancellations must occur via phone or email.

Confidentiality

All communications between you and I will be held in strict confidence unless you provide me with written permission to release information about your treatment. If you participate in couples or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release.

There exceptions to confidentiality that are mandated by law. I am required to report instances of suspected child or elder abuse or neglect. I am also required to break confidentiality when I have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, The Patriot Act of 2001 requires therapists in certain circumstances, to provide

FBI agents with records 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.

I do participate on a consultation team and/or receive consultation or supervision. Please ask me about the nature of consultation and how your privacy is protected.

Minors and Confidentiality

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 may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with me.

Availability Between Sessions

Telephone consultations between sessions are welcome but will be kept brief, as due to the nature of our work, it is best that our communication happen in person. However, we may schedule a phone session between appointments and/or phone coaching may be part of your therapy. Depending on the nature of our work, phone coaching may be a part of your treatment. We will discuss this directly if it is a part of our work. **If you need emergency assistance please contact 911.**

About the Therapy Process

It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Due to the varying nature and severity of problems and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome.

Electronic Forms of Communication

The best way to reach me between sessions and ensure the confidentiality is by phone. With that said, I understand that many people wish to communicate by email. If you choose to contact me via email please know that your privacy cannot be ensured as a third party could intercept communication or access information that is electronically stored. For this reasons, if I reply to you via email, responses will be brief.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. For many

reasons, **it is a good idea that to collaboratively plan for your termination, and you may discontinue therapy at any time.** If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, a referral, changing your treatment goals, or terminating your therapy.

Your signature indicates that you have read this agreement for services carefully and understand its contents.
Please ask me to address any questions or concerns that you have before you sign!

_____ _____

Client Signature and Date Therapist Signature and Date

_____ _____

Client Signature and Date Parent/Guardian (if client is a minor)

Informed Consent for DBT Skills Group

This is intended to provide you with important information regarding your participation in skills group. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents. You are also free to ask questions at any time about our experience and professional orientation.

Fees for Services

Fee is $70.00 per session, monthly amount is due the first class of each month, unless we come to another arrangement. If you agree to participate in skills group, you are expected to pay for the entire month, even if you choose to drop out of group prematurely. If you require special arrangements, please discuss with us directly.
Fee agreed upon: _____

Confidentiality

All communications between you and facilitator/co-facilitator will be held in strict confidence unless you provide us with written permission to release information about your treatment. Since all group members are expected to be in individual therapy, we will obtain written consent at intake to speak with your therapist.

There are exceptions to confidentiality that are mandated by law. We are required to report instances of suspected child or elder abuse or neglect. We are also required to break confidentiality when we have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, The Patriot Act of 2001 requires therapists in certain circumstances, to provide FBI agents with records 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.

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Minors and Confidentiality

Communications between skills trainers 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, we may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with me.

Availability Between Sessions

The role of the skills trainer is akin to a teacher. Skills coaching or help with other clinical matters must happen with your individual therapist. We ask that you contact us in advance to let us know if you will not be able to attend group. It is best to communicate by phone. If you need to communicate by email, you are welcome to do this but please know that confidentiality cannot be assured in this form of communication. **If you need emergency assistance please contact 911.**

Crisis calls

If there is a medical or psychiatric emergency at any time of the day/night then call 911 or mobile crisis at 1.800.309.2131. Please also contact your primary therapist.

Ending participation in skills group

You are welcome to repeat participation in skills group for as long as you and your therapist find this to be effective and supportive. Many people find that going through the entire skills learning process twice is an optimal amount of time to learn and integrate the material. You will be asked to leave skills group if you break agreements outlined on the group guidelines and are not willing to make necessary changes.

Your signature indicates that you have read this agreement for services carefully and understand its contents.

Please ask me to address any questions or concerns that you have before you sign!

_____ _____

Participant Signature/Date Skills Trainer Signature/Date

_____

Parent/Guardian Signature/Date
(if client is a minor)