TREATMENT POLICIES

Shelley C. Wilson, LMFT, LPCC

CONFIDENTIALITY

All information that you share with me will be held in confidence. I will not release any information to any agency or person without your consent, except under the following conditions:

- If you threaten suicide or pose other danger to yourself;
- If you threaten homicide or other serious physical harm to another person or property;
- If there is a reasonable suspicion of child abuse, elder abuse or dependent adult abuse;
- If necessary to comply with a court order or subpoena.

Additionally, a federal law commonly known as the Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers, documents and other items and prohibits the therapist from disclosing to the client that the FBI sought or obtained the items under the Act.

If you participate in couples or family therapy, I will not disclose confidential information about your treatment unless all persons who participated in the therapy with you provide their written authorization to release. I will not disclose information communicated privately to me by one family member, to any other family member without permission.

I am willing to communicate with you via video (e.g. FaceTime) cell phone, text and/or email; however, due to technological limitations, there is no assurance regarding the confidentiality of those communications.

FEES

My fee for psychotherapy is $140 per approximately 50 minute session. Sessions are scheduled for this length of time and you may be charged for any additional time. I expect occasional telephone contact and do not charge for it. I will charge fees if the frequency and/or length of phone calls (10+ minutes) become an issue.

PAYMENT

Full payment is expected at each therapy session. I accept cash, check or Mastercard and Visa credit cards. Having your check filled out in advance will save time in the session. A service charge of $25 will be added for a check returned by the bank for any reason. If you intend to utilize insurance benefits, you are responsible for submission of the claim to the insurance company and for payment of my entire fee. I am not a designated provider for any insurance companies.

Shelley C. Wilson, LMFT, LPCC
41690 Enterprise Circle North, Suite 209, Temecula, CA 92590
(949) 922-7800

APPOINTMENTS AND CANCELLATIONS

When a session is scheduled, I reserve that time for you. If you do not show up for your appointment, no one else can use that time. An appointment, which is missed or cancelled without 24 hours prior notice, shall be billed at the full fee and must be paid promptly.

You and I may decide to use interactive audio, video or data communications ("telemedicine") for psychotherapy. If you agree to participate in telemedicine, signing these treatment policies evidences your consent to telemedicine.

AVAILABILITY

I usually am not immediately available to answer the telephone or text. Please leave a message on my voicemail. I make every effort to return the call on the same business day. I will return your call but cannot guarantee that calls will be returned immediately. I am generally available only during the business week and do not retrieve my messages on a regular basis on the weekends. I am unable to provide 24-hour crisis service. If you are having an immediate crisis, contact your local mental health center, the police, the emergency service of your local hospital, or other appropriate agency. **In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.**

If you cancel your regularly scheduled appointment, I may not have another appointment available for you until the following week although I will reschedule the session as soon as possible. I attend professional conferences and take vacations during the year; therefore, I will give you prior notice if I will not be available for an appointment.

CONSULTATION

If I make reports, appearances, and/or consultations on your behalf to other persons or agencies, I charge an appropriate fee.

PROCESS AND QUESTIONS

It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide and the specifics of your situation, I will provide recommendations to you. I believe that we are partners in the therapeutic process. You have the right to agree or disagree with my suggestions. The first few sessions will involve history taking and evaluation. This can last from one to five sessions. During this time, we both decide if I am the best professional to provide the services you need in order to meet your treatment goals.

You have the right to terminate therapy at any time. It is a good idea to plan for your termination, in collaboration with me. I will discuss a plan for termination with you as you approach completion of your goals for therapy. If either of us

believes it is not in your best interest to continue working with me, termination will occur and I will provide you with referrals.

It is natural for strong feelings to arise during the therapeutic process. You may experience anger, frustration, and/or curiosity regarding my course of action or process. It is important for us to discuss these issues whenever they occur. This honesty is essential for therapy to be effective and will help me to deal directly with your needs. I encourage you to bring up pressing issues early enough in the session so that we can work on them in the session. If you have concerns, complaints or expectations that are not being met, please address these issues with me.

INDEPENDENT PRACTICE

Shelley C. Wilson is a sole proprietor and not in a joint business relationship with any other counseling offices, sober support staff or treatment centers.

CONSENT TO TREATMENT

I consent to evaluation and treatment as determined by Shelley C. Wilson, LMFT, LPCC, and myself. I acknowledge that no guarantees have been made to me regarding the result or outcome of evaluation and treatment. I fully understand and accept all the terms and conditions of this document.

Client's signature:_____ Date:_____

Printed name:_____

Shelley C. Wilson, LMFT, LPCC
41690 Enterprise Circle North, Suite 209, Temecula, CA 92590
(949) 922-7800

TREATMENT OF MINORS

I give my consent to Shelley C. Wilson, LMFT, LPCC to provide assessment and psychological treatment services for my children and family. Communications between a therapist and minor clients are confidential. However, parents or other guardians who authorize the child's treatment are often involved in their therapy. Consequently, the therapist, in the exercise of her professional judgment, may discuss the treatment progress of a minor client with the parent or guardian. Minor clients and their parents are urged to discuss any questions or concerns that they have on this topic with the therapist.

_____ Birthdate:_____
Name of Minor

_____ Birthdate:_____
Name of Minor

_____
Parent/Guardian Signature

Shelley C. Wilson, LMFT, LPCC
41690 Enterprise Circle North, Suite 209, Temecula, CA 92590
(949) 922-7800