



**(re) defining culture's
definition of health**

3160 Camino del Rio S #304

San Diego, CA 92108

T 619-819-0283

F 619-819-0284

www.potentiatherapy.com

Policies & Procedures

CONFIDENTIALITY

Your therapist is required to report suspected past or present abuse and/or neglect of children, dependent adults, and elders to the appropriate authorities based on information provided by the client or collateral sources. Information may also be released to designated parties by written authorization of clients or legal guardians. Therapists are required to release information obtained from clients or from collateral sources (other individuals involved in a client's psychotherapy, such as parents, guardians, spouses) to appropriate authorities to the extent to which such disclosure may help to avert danger to a client or to others, e.g.; imminent risk of suicide, homicide, or destruction of property that could endanger others. If a client is using confidentiality as a means of avoiding legal punishment, the therapist must break confidentiality because the therapist may not aid or abet committing a crime. Psychotherapists reserve the right to release financial information to a collections agency, attorney, or small claims court for delinquent client accounts. Other than the above exceptions, your therapy sessions are held with the strictest ethical standards to honor your confidentiality. Protected as confidential information includes: the acknowledgment of your presence in therapy, documentation you give to your therapist, and all of your therapist's clinical notes. With the goal of giving you the best clinical care, your therapist will regularly engage in peer consultation or supervision during which relevant information about clients may be disclosed. Potentia employs Marriage and Family Therapy Interns who are supervised under a licensed clinician at Potentia. Your cases will be discussed with his/her Potentia supervisor for consultation on a weekly basis. Your confidentiality is still honored strictly during these supervision meetings. If you have any questions or concerns regarding your confidentiality and clinical supervision, please make sure to address these concerns with your therapist.

Initial Here _____

COMMUNICATION

You may leave messages at any time on our 24-Hour voicemail system. You will receive a response within 24-48 hours. If you have a life-threatening or urgent situation, please call 911, or the San Diego County Crisis Hotline at 888-724-7240. Phone consultations more than 10 minutes will incur a pro-rated charge. Email communication is also appropriate for brief questions or communications to your therapist and will be discussed at your next session. It is important to note that email is not 100% secure. Any emails that are



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relevant to your treatment will be printed out and kept in your file. If you have a timely question, email and phone are recommended.

Initial Here _____

APPOINTMENTS

24 hour notice is expected when canceling an appointment. You will be charged your full fee, which is usually not reimbursed by insurance. Emergencies and extreme circumstances are taken into consideration.

Initial Here _____

FINANCIAL ARRANGEMENTS

Payment is due at the time services are rendered either by Cash, Check, or Credit Card. We have agreed that your fee(s) for professional services are \$_____ per individual/couples/family session, and/or \$_____ per group session. Consultations with other professionals and reports prepared on your behalf will be charged a pro-rated fee. Assessment testing is charged on a per instrument basis. A \$25 charge is made for any check returned to us as non-payable for any reason. Accounts over 90 days past due may be sent to collections and additional fees may be applied.

Initial Here _____

INSURANCE

Potentia therapists are out-of-network therapists and are not on any insurance panels. If you have PPO insurance and you would like to receive reimbursement from your insurance plan, you will be provided a super bill that will have all of the necessary information for you to submit to your insurance company.

Initial Here _____

APPROPRIATE PROFESSIONAL CONDUCT

As with any professional relationship, the psychotherapeutic relationship requires high standards of moral, ethical, and appropriate conduct on the part of the psychotherapist. Specifically, any form of sexual intimacy between a therapist and a client is never appropriate. The booklet "Therapy Never Includes Sex" is available to you upon your request.

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As a client, I have read and understand (or have asked for clarification about) the information presented in this form, and consent to treatment within the aforementioned guidelines.

1. _____
 Sign Name Print Name Date

2. _____
 Sign Name Print Name Date

Therapist:

 Sign Name Print Name Date

I acknowledge my credit card information will be kept on file to be used for session fees in which I do not provide payment (unless other arrangements have been made with my therapist). Charges for missed appointments not cancelled within the 24 hours advanced notice, returned check fees and the amount of the check paid, and overdue balances of more than 30 days will be billed to my account. My credit card will only be used under these circumstances or when I have not provided payment in another form (i.e. cash or check). By signing below and providing my credit card information, I authorize Potentia Family Therapy, Inc. or my individual therapist to charge my credit card.

1. _____
 Sign Name Print Name Date

2. _____
 Sign Name Print Name Date

Name on Credit Card: _____

Billing Address on Card: _____

Credit Card Number: _____

Expiration Date: _____ CVV (3 digit code on back): _____

Phone Number on record with Card: _____

Credit Card Type: Visa • Mastercard • AmericanExpress • Discover