Disclosure Statement & Agreement for Psychotherapy Services

Welcome to the office of Dr. Brooke Buccola. This document is intended to provide you with important information regarding the practices, policies, and procedures of this office and to clarify the terms of the professional therapeutic relationship. Please read the entire document carefully and be sure to ask any questions that you may have regarding its contents.

Information About Your Therapist

Brooke Ann Buccola, PsyD, LMFT
562-650-7207
drbrookebuccola@yahoo.com
www.drbrookebuccola.com
Licensed Marriage and Family Therapist
License #MFT 50417 issued by the State of California Board of Behavioral Sciences

Education

Doctorate in Psychology with an emphasis in Marriage and Family Therapy
Alliant International University/California School of Professional Psychology
Master of Arts in Marriage and Family Therapy
Alliant International University/California School of Professional Psychology
Bachelor of Arts in Psychology, cum laude
California State University, Long Beach

Fees

Therapy sessions are 50 minutes in duration for individuals, couples, and families and 45 minutes for children. The full fee for service is $180 per therapy session. Fees are payable at the time of each session. Accepted forms of payment include cash, checks, or card. There will be a $15 charge on returned checks.

Insurance

Dr. Buccola is primarily an out of network provider, with in network contracts with Aetna PPO. It is the patients responsibility to contact their insurance company and find out what type, if any, coverage or reimbursement they will provide for services provided by Dr. Buccola. Due to the complexities and time delays of insurance reimbursements, this office requires that each session be paid in full at the time of service. If a patient wishes to utilize his or her health insurance for reimbursement, the office will provide you with a superbill the patient can submit to their insurance company upon request of the client. Any necessary follow-up with the insurance company regarding claim status is the responsibility of the patient. As a reminder, if the insurance coverage includes an annual deductible, the patient will begin to receive reimbursement after the deductible has been met. Insurance cannot be billed for no-shows or late

cancellations (less than 24 hours notice). Under such circumstances, the patient will be responsible for payment of the full fee for the missed therapy session.

Confidentiality

Information disclosed in therapy sessions is strictly confidential and will not be released to any third party without written authorization, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, reporting suspected child abuse, elder abuse, or dependent adult abuse; if the therapist feels that the client may be a danger to him or herself or to the person or property of another; if the patient is gravely disabled; or if disclosure is court ordered. Communications between the therapist and patients who are minors (under the age of 18) are also strictly confidential. Parents or legal guardians who have authorized the treatment may be generally advised about the progress of therapy. However, for psychotherapy to be successful, there must be a trusting relationship between the therapist and the child. Parents or legal guardians will be informed if the therapist feels that the child is a danger to him or herself or to the person or property of another. All other ethical and legal limitations to confidentiality apply. Dr. Brooke Buccola, upon using reasonable judgment, may discuss aspects of your treatment in consultation with other mental health professionals who are providing services to you (e.g., psychiatrist). She may also at times speak to other mental health professionals about your treatment for the purpose of professional consultation, with all identifying information thoroughly disguised. All records and psychotherapy notes constitute the therapist's clinical and business records which, by law, the therapist is required to maintain. Such records are the sole property of Dr. Brooke Buccola. Should you request a copy of these records, you must do so in writing. Dr. Brooke Buccola reserves the right, under California law, to provide a treatment summary in lieu of actual records. All such records can be subject to court subpoena under extreme circumstances. Most records are stored in locked files. Some are stored electronically in compliance with ethical and legal requirements.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled on a weekly basis. Consistent attendance greatly contributes to a successful therapy outcome. In order to cancel or reschedule an appointment, the patient must contact Dr. Brooke Buccola at least 24 hours in advance of the scheduled appointment. If a patient must cancel an appointment without a 24 hour notice, he or she will be responsible for payment of the full fee for the missed session. Exceptions may be made in cases of extreme illness or emergency.

Voicemail and Emergencies

You may leave a voicemail message for Dr. Brooke Buccola and she will make every effort to return your call promptly. For maximum therapeutic effectiveness and to ensure confidentiality, telephone contacts are

generally for the sole purpose of appointment scheduling. In the event of an emergency involving a threat to your safety or the safety of others, please call 911 or go to your local emergency room.

Termination of Therapy

You have the right to discontinue therapy at any time. Dr. Brooke Buccola reserves the right to terminate therapy at her discretion. Reasons for termination may include, but are not limited to, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, or untimely payment of fees.

Acknowledgement

I have read this document completely and have been given the opportunity to ask questions and have them answered. I fully understand the information contained herein regarding the practices, policies, and procedures of this office.

I agree to abide by the terms and conditions set forth in this agreement and hereby consent to treatment for me or my minor child by Dr. Brooke Buccola.

Patient Name_____

Patient Signature _____ Date _____

Parent or Guardian of Minor

Guardian Name_____

Relationship to Minor_____

Guardian Signature_____ Date_____

Guardian Name_____

Relationship to Minor_____

Guardian Signature_____ Date_____

****CUSTODY**** (please circle one)

Joint Legal Custody
Joint Physical Custody
Sole Legal Custody (Parent name_____)
Sole Physical Custody (Parent name_____)