

Michelle Hardeman-Guptill MA, LMFT, CCHT
Lic. # LMFT 99852
406 Chinn St.
Santa Rosa, CA 95404
(707) 387-0167

Informed Consent

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents.

I have worked with children and their families for the last 15 years. I have played various roles in different environments and therefore I have an eclectic and solution focused approach to the therapeutic process. I have experience working with clients from the age of 4 through adulthood. I have a particular affinity for adolescents and transitional aged youth.

I am a Licensed Marriage and Family Therapist, a Certified Clinical Hypnotherapist and a Certified Matrix Reimprinting Practitioner. I am trained in the specific modalities of DBT Skills, Trauma Focused-Cognitive Behavioral Therapy, Motivational Interviewing, EFT/Matrix Reimprinting, Clinical Hypnotherapy, Art and Drama Therapy. I blend various experiential techniques (role play, sand tray, gestalt empty chair, myth and metaphor, art, movement etc.), along with the evidence based modalities, as a way to deepen the exploration and practice of new skills, thoughts and behaviors.

It is important that you are aware that when using Clinical Hypnotherapy and/or EFT/Matrix Reimprinting, I may touch your face, collar bone/shoulders, hands, or feet. If this is something that you are uncomfortable with, please let me know and we will modify the protocols to suit your needs. Your comfort is the most important thing. I will check in with you regularly to ask if it is ok to touch you and it is perfectly acceptable to tell me that the answer is no.

My theoretical orientation is Integrative; taking bits and pieces from humanistic therapy, cognitive behavioral therapy, family systems therapy, relational therapy, attachment theory, narrative therapy and expressive therapies. My work is heavily trauma informed. I take a wholistic approach in helping others help themselves. I do not believe that therapy needs to be a lengthy process. In fact, I feel that therapy that is brief, solution focused and client-driven is most effective, empowering and long-lasting.

The name of this practice is Michelle Hardeman-Guptill LMFT and the individual therapist who operate this practice is Michelle Hardeman-Guptill LMFT, License # LMFT99852.

Fees:

The fee for service is \$120.00 per individual therapy session.

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The fee for service is \$180.00 per conjoint (marital /family) therapy session, Regression Hypnotherapy and Matrix Reimprinting sessions.

The fee for service is \$60.00 per group therapy session (minimum of 6 clients).

Individual Sessions are 50 minutes and conjoint (marital /family) sessions are approximately 80 minutes in length. Regression Hypnotherapy and Matrix Reimprinting sessions are approximately 80 minutes.

Fees are payable at the time that services are rendered. Please ask if you wish to discuss a written agreement that specifies an alternative payment procedure.

Insurance:

I do not currently take insurance. It is possible to ask your insurance company to enter into a single member agreement with me. Please ask to discuss this at our first meeting if this is something you would like to consider.

If I do begin taking insurance, please inform me if you wish to utilize health insurance to pay for services. If I am a contracted provider for your insurance company, I will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although I am happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with me.

I am currently contracted with LEAP EAP Services. If your company has an EAP service and you would like me to be your therapist, please provide them with my information and I will see if they are willing to contract with me.

If for some reason you find that you are unable to continue paying for your therapy, please inform me as soon as possible. I will help you to consider any options that may be available to you at that time.

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Confidentiality:

All communications between you and I will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your 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 such information. However, it is important that you know that I utilize a “no-secrets” policy when conducting family or marital/couples therapy. This means that if you participate in family, and/or marital/couples therapy, I am permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family.

Please feel free to ask me about my “no secrets” policy and how it may apply to you.

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child, dependent adult or elder abuse. Therapists may also be required or permitted to break confidentiality when they 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. Therapy is not intended to be used for court related purposes. If I am asked to share documents related to your therapy in court, I will generally refuse until/unless a judge orders that the records be brought into court. If I am asked to testify in court, my fees are double my current fee. My time includes time spent preparing, traveling and analyzing the chart.

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, in the exercise of my professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. In order to build rapport with youth and adolescents, it is important for them to know that what they tell me is confidential. Generally, unless there is a safety issue, I will not disclose details of the session other than progress toward goals or skills learned that can be

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reinforced at home. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with me.

Appointment Scheduling and Cancellation Policies:

Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify me at least 24 hours in advance of your appointment. If you do not provide me with at least 24 hours' notice in advance, you are responsible for payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions.

Therapist Availability/Emergencies:

You are welcome to contact me in between sessions. However, as a general rule, it is my belief that important issues are better addressed within regularly scheduled sessions. Any time over 10 minutes will be charged per minute at my normal rate.

You may leave a message for me at any time on my confidential voicemail. If you wish for me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during my normal workdays within 24 hours. If you have an urgent need to speak with me, please indicate that fact in your message and follow any instructions that are provided on the voicemail. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance. You can also call 1-800-746-8181. Please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call.

You should be aware that I am generally available to return phone calls within approximately 48 hours.

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For your information, the following resources are available in the local community to assist individuals who are in crisis:

Crisis Hotline: ((800) 746-8181) North Bay Suicide Prevention Hotline: ((855) 587-6373)
Crisis Stabilization Unit (707-565-6900) Youth Shelter: (Dream Center SAY (707) 544-3299)
Domestic Violence Help: (Family Justice Center Sonoma County (707) 565-8255 or YWCA
Domestic Violence Hotline – (707) 546-1234 (24 hours)) Hospital: (Santa Rosa Memorial
Hospital (707) 525-5300) Other: NAMI Sonoma County ((707) 527- 6655) , Verity Rape Crisis
Center ((707) 545-7270)

Therapist Communications:

I may need to communicate with you by telephone or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform me if you do not wish to be contacted at a particular time or place, or by a particular means.

My therapist may call me on my home phone. My home phone number is: () _____
My therapist may call me on my cell phone. My cell phone number is: () _____
My therapist may send a text message to my cell phone. My cell phone number is: () _____
My therapist may call me at work. My work phone number is: () _____
My therapist may communicate with me by e-mail. My e-mail address is: _____
My therapist may send a fax to me. My fax number is: () _____

My therapist may send mail to me at my home address. My therapist may send mail to me at my work address.

Sensitive, clinical information is to be discussed over the phone or in-person as deemed appropriate by the therapist. For appropriate e-mail or text communication I will respond to your e-mail or text within 24 hours. Potential risks of using electronic communication may include, but are not limited to; inadvertent sending of an e-mail or text containing confidential

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information to the wrong recipient, theft or loss of the computer, laptop or mobile device storing confidential information, and interception by an unauthorized third party through an unsecured network. E-mail messages may contain viruses or other defects and it is your

responsibility to ensure that it is virus-free. In addition, e-mail or text communication may become part of the clinical record. You may be charged for time I spend reading and responding e-mail or text messages.

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 to 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.

I will work with you to develop an effective treatment plan. Over the course of therapy, I will attempt to evaluate whether the therapy provided is beneficial to you. Your feedback and input is an important part of this process. It is my goal to assist you in effectively addressing your problems and concerns. However, 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 or result.

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. 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 the completion of your treatment goals.

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, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

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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 about this information before you sign.

Name of Client

_____ Signature

_____ Date