Jaimi Taylor, M.A., LMFT

Licensed Marriage and Family Therapist # *110094*

Welcome to my practice. This document contains important information about my professional services and business policies. When you sign this document, it will represent an agreement between us, so please read it carefully. We can discuss any questions you have at our first session or at any time in the future.

My private practice in Palo Alto is located at:
2460 Park Blvd. Suite 6
Palo Alto, CA 94306

And also work in the Community Health Collaborative (CHC) in Los Altos at:
919 Fremont Ave. Suite 200
Los Altos, 94024

PSYCHOLOGICAL SERVICES

Most people who obtain psychotherapy benefit greatly from the process. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems. However, I cannot guarantee that this will be your experience. A joint effort between therapist and client is essential for therapy to be successful. I will use multiple different methods to help you address the specific concerns that you bring forward in therapy and I will create a treatment plan tailored to your unique needs. Psychotherapy involves active effort and participation on your part, and you will need to work on things we discuss outside of sessions for treatment to be most effective. Overall progress and success in psychotherapy will vary depending on several factors, including your motivation, effort, and life circumstances.

While there are many potential benefits of psychotherapy, there are some risks as well. These may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, these are all natural parts of the therapeutic process and can be necessary for change.

Our first few sessions will involve a comprehensive evaluation of your needs, at which time I will offer you some first impressions of what our work together might include, such as suggested treatment plan, procedures, and goals. You should evaluate this information along with your own opinions of whether you feel comfortable working with me, and we will make a joint determination as to whether it would be appropriate for us to work together. If you ever have questions about the therapeutic process, we should discuss them whenever they arise. In the event that we determine that working together would not be appropriate, I am happy to help you set up a meeting with another mental health professional.

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For those seeking treatment for Eating Disorders or FBT: please note that this treatment may initially appear to "make things worse" as the eating disorder gets "cornered". In our initial meetings, we will discuss expectations and likely course of treatment, as part of the initial evaluation.

***Please note that all clients being seen for an eating disorder are required to also have a medical provider who is regularly monitoring medical status, and may also require regular appointments with Registered Dietitian (RD) as well.**

APPOINTMENTS & CANCELLATION POLICY

All psychotherapy sessions, unless otherwise specified, are 50-minutes, and initial family sessions, unless otherwise specified, are 90-minutes in length. I use the first few sessions to conduct an evaluation so that we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, we will usually schedule a weekly 50-minute session at a time that we agree on, although sessions may be scheduled more or less frequently based on your needs. The day and time scheduled for your session is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24-hour notice.

If you miss a session without canceling, or cancel with less than 24-hour notice, my policy is to collect the full payment for the session. If it is possible, I will try to find another time to reschedule the appointment within the same week. In the event that you miss two consecutive sessions and I have not been able to contact you, your assigned appointment day and time may be forfeited and you will not be scheduled or billed for further sessions until we agree to resume treatment.

If you will be arriving late to a session, please contact me by email or telephone so I know to expect you. In addition, if you are late to your session we will still need to end on time.

PROFESSIONAL FEES & PAYMENTS

My standard fee for a 50-minute session is $200.00 and 90-minute session is $310. Payment is due in full at each session in the form of cash, check, credit card or Venmo. Any returned checks are subject to an additional fee of $50. I request a Credit Card number be held on file to ensure payment, in case payment is not secured by other means, per this contract.

In addition to weekly appointments, I charge an hourly rate of $200 for other professional services you may need, though I will prorate the fee if I work for periods of less than one hour. Billed services

include telephone conversations lasting longer than 10 minutes, report writing, agreed-upon consultations or meetings with other professionals on your behalf, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. Payment schedules for other professional services will be agreed on when they are requested.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, including preparation, travel, and attendance, even if I am called to testify by another party.

In the unlikely event that your account has not been paid for more than 60 days, I reserve the right to use the signed credit card information on file, an attorney, small claims court, or collection agency to secure payment. In most collection situations, the information released includes your name, nature and dates of services provided, and amount due. You will be responsible for any fees incurred during the collection process.

If at any time during treatment you become unable to pay for my services, I will make every effort to help you secure alternative treatment options.

INSURANCE REIMBURSEMENT

I am an out-of-network provider for all insurance companies. I can provide you with a “Superbill” on a monthly or quarterly basis that you can submit to your insurance company to request reimbursement. The information on this document would include your name, nature and dates of services provided, amount paid, DSM diagnoses, and CPT codes. Please note that not all insurance companies reimburse for out-of-network providers. I encourage you to contact your insurance company directly with questions about your coverage.

If your insurance does not cover out-of-network providers, you may be able to pay for therapy out of your pre-tax income using an HSA or FSA account.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep confidential treatment records. Except in unusual circumstances that involve danger to yourself, you have the right to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them with me so that we can discuss the contents. You also have the right to have a summary or copy of your treatment records to any other health care provider at your

written request. Clients will be charged my hourly fee for any professional time spent responding to records requests.

CONTACTING ME

I am often not immediately available by telephone, as I do not answer my phone when I am with clients. If you call and I am unavailable, you may leave a message on my confidential voicemail and I try to return all calls within two business days. I am not available to return phone calls on evenings, weekends, or holidays. My email is also confidential and I tend to be able to respond more quickly via email.

If you are unable to reach me and feel that you cannot wait for a return call or need to speak to someone urgently, you can contact your primary care physician, your psychiatrist if you have one, or the **24-hour Santa Clara County Crisis Hotline at (855) 278-4204.** If you feel that you are unable to keep yourself safe or are experiencing a medical or psychiatric emergency please call 911 or go to the nearest emergency room.

I will make every attempt to inform you in advance of planned absences where I will be unavailable for an extended period of time. During these times, you may be provided with the name and phone number of a colleague to contact in my absence.

ELECTRONIC COMMUNICATION POLICY

While the use of electronic communications is common and convenient, these types of communications can put your privacy at risk and can be inconsistent with the law and standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to maintain consistency with ethics and the law.

Email Communications. I use email communication only with your permission and primarily for administrative purposes. This means that email exchanges are usually limited to making and changing appointments, billing matters, and other non-clinical issues. While my email is considered HIPAA compliant, it is not considered a completely secure way to contact me for clinical issues. If you need to discuss a clinical matter, please call me so we can discuss it on the phone or bring it up at your next therapy session.

Text Messaging. Text messaging is a very un-secure and limited mode of communication and not advised as a method of communication. However, and with your permission, it can be used for administrative purposes only (appointment times, for example) similar to email. It is not to be used for any emergency situations.

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Social Media. I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship immediately. This is because these types of casual social contacts can create significant security risks for you. I may participate in various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our sessions together.

I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me via social networks, as I will not respond.

Websites. I have a website that you are free to access. I use it for professional reasons to provide information to others about my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss these during your therapy sessions.

Web Searches. I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. There is an incredible amount of information available about individuals on the internet, much of which may be inaccurate or unknown to the individual. If you encounter any information about me through web searches or in any other fashion, please discuss this with me during our sessions so that we can address its potential impact on your treatment.

Recently it has become popular for clients to review their health care providers on websites. Unfortunately, mental health professionals cannot respond to such reviews because of confidentiality restrictions. If you encounter online reviews of me, please share them with me so we can discuss any potential impact they may have on your therapy. I request that you not rate my work on any of these websites, both during or after our treatment together, as it has significant potential to damage our ability to work together currently or in the future.

MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. When working with adolescents and their families, I generally use the first few sessions as an initial evaluation to determine whether the therapeutic work will focus primarily on individual work with the adolescent, family work, or both. Parents, guardians, and/or other family members will need to attend one or more sessions during this initial evaluation process.

If it is agreed that the therapeutic work will primarily focus on individual treatment with the adolescent, I will request an agreement between the adolescent client and the parents allowing me to share general information about treatment goals, progress, and attendance.

If it is agreed that the work will primarily focus on sessions involving the family, I will request that the agreed upon family members attend all sessions unless other arrangements have been made.

If I am concerned about the health or safety of an adolescent client, I may need to disclose this information to the adolescent's parents, guardians, or other providers.

In the case of eating disorders, this includes disclosure of any eating disorder symptoms (purging, exercise, self-harm, substance abuse), as these behaviors are both highly dangerous as well as the focus of the treatment. In these instances, I will make efforts to notify the adolescent of my intention to disclose information ahead of time and to discuss any objections that are raised.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information about our work to others with your written permission. However, California State Law states that there are exceptions to a client's confidentiality in certain circumstances. These situations very rarely occur in my practice and I will make every effort to discuss breaches to confidentiality with you in advance.

I can, or must, breach confidentiality if:

You are a danger to yourself, threaten to harm yourself, or are actively suicidal. I may contact people you know to inform them of this danger, and I may also contact the police to check on your welfare. I may also be obligated to have you evaluated for hospitalization.

You threaten to harm, assault, or kill another specific person(s) or I have reasonable cause to believe that you will do so. I am required by law to warn the intended victim and notify the police. I may also be obligated to have you evaluated for hospitalization.

A member of your family informs me that you seriously intend to harm, assault, or kill another person(s). I am required by law to warn the intended victim and notify the police. I may also be obligated to have you evaluated for hospitalization.

You are seeking psychological services to enable someone to commit a crime, or to avoid detection or apprehension yourself.

You are gravely disabled due to a mental disorder and are unable to provide yourself the basic needs of food, clothing, or shelter. I may also be obligated to have you evaluated for hospitalization.

You disclose known or suspected abuse or neglect of a child, dependent adult, or elderly adult (over 65 years old) by you or someone else. In these instances, reporting is a requirement for all health care providers, and I will file telephone and written reports notifying relevant public offices, such as Child or Adult Protective Services. Specific instances that I will report include, but are not limited to, if you are under 16 years old and are the victim of a crime, if you are under 18 years old and I reasonably suspect that you are a victim of child abuse, if you are over 65 years old and I believe that you are the victim of abuse or neglect, and if you are a parent/guardian of a minor and engage in activities that constitute abuse or neglect of a child under the law.

You become involved in a legal proceeding where your mental competence is at issue, you have filed a lawsuit against anyone and are claiming mental or emotional damages as a part of the suit, or you file a lawsuit against me for breach of duty or incompetence.

In most other types of legal proceedings, you have the right to prevent me from providing any information about your treatment.

You die, and the information you had disclosed to me or is documented in your record is important to an issue between parties making legal claims through you. Or you die, and information I have is important in ascertaining your intent, or deciding an issue, concerning a deed of conveyance, will, or other writing of yours affecting your interest in property.

There may be other circumstances where I share information about you in order to provide you continuity of care and the best treatment possible.

Information about you may also be shared with others if:

I am out of the office for an extended period of time and a colleague is covering my practice, as I may advise them in advance of issues that may arise with my clients during my absence.

I seek consultation from another professional regarding your care, though I will make every effort to conceal your identity. Also, the professionals with whom I consult are legally bound to maintain confidentiality.

You submit a “Superbill” to your insurance company for reimbursement, as this document will contain diagnosis and procedure codes.

You are working with a team of professionals (psychologist, nutritionist, psychiatrist, and/or physician), including myself, and you have given me written permission to discuss your ongoing care with this team.

You have waived your rights to privilege or give written consent to limited disclosure by me.

OFFICE SPACE DISCLOSURE

Each provider in Suite 200 of 919 Fremont Ave. Los Altos, CA 94024 operates as an independent entity and makes no professional representation nor bears any legal liability for the patient care provided by any other provider operating on premise and/or under the name The Community Health Collaborative.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will discuss this with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment.

You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

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CONSENT TO PSYCHOTHERAPY

I have read the information in the Therapist-Client Service Contract. I have discussed this document and its content with Jaimi Taylor, LMFT and I have had any questions or concerns addressed to my satisfaction. I fully accept, understand, and agree to abide by the contents and terms of the Therapist-Client Service Contract, and I consent to participate in an evaluation and/or treatment with Jaimi Taylor, LMFT

_____ **Signature of Client**

_____ **Printed Name of Client**

_____ **Date**

If client is a minor:

_____ **Signature of Parent/Legal Guardian**

_____ **Printed Name of Parent/Legal Guardian**

_____ **Relationship to Client**

_____ **Date**

_____ **Signature of Parent/Legal Guardian**

_____ **Printed Name of Parent/Legal Guardian**

_____ **Relationship to Client**

_____ **Date**

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CLIENT INFORMATION FORM

Last name _____First _____ Middle _____

Address _____

City _____State _____ Zip _____

Home phone _____ May I leave voice messages? ☐ Yes ☐ No

Cell phone _____ May I leave voice/text messages? ☐ Yes ☐ No

Email _____ May I email you? ☐ Yes ☐ No

Referred by: _____

Please note: Email is not considered to be a confidential medium of communication. It is only recommended for contact regarding scheduling and is not recommended for communication of therapeutic issues.

Birth Date _____Age _____Gender _____Ethnicities _____

Occupation _____Education Level _____

Contact in case of emergency:

Name _____ Phone _____

Relationship _____

Permission to contact with a signed release of information (ROI)? ☐ Yes ☐ No

Other providers on your team: (name and numbers)

_____

_____

_____

_____

Permission to contact the above with ROI? ☐ Yes ☐ No

I have received, read and signed the HIPAA and Service Contract forms, and agree with all the terms: ☐ Yes ☐ No

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CREDIT CARD INFORMATION AND PRE-AUTHORIZATION FORM

Payment is accepted in the form of cash, check, or credit card, and is due at the time of the session. Clients are asked to provide up-to-date credit card information to keep on file. If your credit card information changes, please let me know so we can update this form. Your credit card may be charged for "no show" appointments, missed sessions without 24 hour- notice of cancellation, or for any payment that is past due. I will notify you if I intend to charge your credit card for these purposes. By signing below, you authorize, Jaimi Taylor, LMFT, to keep your signature and credit card information on file for the duration of therapy, and to charge your credit card in accordance with the policies outlined above.

_____
Client's Name

_____
Cardholder's Authorizing Signature

_____
Cardholder's Name

_____
Credit Card Number

_____/_____
Expiration Date

_____
CVV

_____
Cardholder's Zip

In addition, please indicate if you would like to use this credit card for payment after each session:

☐ Yes ☐ No

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ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Jaimi Taylor, LMFT Notice of Privacy Practices effective January 1, 2019.

Name : _____ (please print)

Date: _____

Signature: _____

I am a parent or legal guardian of _____ (patient name). I have received a copy of Jaimi Taylor, LMFT Notice of Privacy Practices effective January 1, 2019.

Name: _____ (please print)

Date: _____

Relationship to Client: ☐ Parent ☐ Legal Guardian

Signature: _____