Daniel Davies, Ph.D., L.E.P.

L.E.P. #3372

OFFICE POLICIES AND PROCEDURES

Please take a moment to read this information. Please initial by each section and sign at the end of the form if you agree to all conditions. If you have any questions, please let me know.

_____ **CONFIDENTIALITY**: I take your privacy and confidentiality very seriously. All information discussed within sessions is confidential and will not be disclosed to anyone without your written permission, except when required by law or by your health insurance provider if you are asking them to help pay for my services.

Disclosure may be legally required when: 1) there is a reasonable suspicion of child or elder abuse. 2) there is reasonable suspicion that a client presents an imminent danger of violence to others, or required pursuant to legal proceedings, or if you file a worker's compensation claim.

In couples or family therapy, or when different family members are seen individually, confidentiality and privileges do not apply between the couple or among family members. I will use my clinical judgment when revealing such information.

_____ **THERAPIST FEES AND INSURANCE**: I have a doctoral degree in school psychology and am a licensed educational psychologist. I am a solo practitioner and have no professional association with the other members of this suite, other than sharing a lease. My fee is $XX for education-related appointments. Appointments last 50 minutes, although longer appointments are available and are sometimes preferred. Fees are payable at the time of service. To assure your full session time, please pay at the start of each session. I do not accept insurance as payment but am able to provide a receipt of service. Please note that the insurance contract is between you and your insurance company and if you seek reimbursement for services, the fee remains your responsibility if for any reason services are not covered.

_____ **CANCELLATIONS**: Since scheduling an appointment means reserving time specifically for you, a minimum of 24 hours is required to reschedule or cancel. If you must cancel, please let me know as soon as possible. You can leave a message at any hour, on any day, including weekends. If I am not notified of a cancellation at 24 hours in advance of your scheduled appointment you will be charged for that time.

_____ **CONSENT FOR PSYCHOLOGICAL TREATMENT**: By signing this form, you are giving consent for services including but not limited to, clinical interview, psychological testing, and education-related therapy as deemed necessary. You are consenting and agreeing only to those services that I am qualified to provide within the scope of my license and training. You are an active participant in our work, have input regarding it, and can decline any particular service you are not comfortable with at any time.

_____ **NOTICE TO CLIENTS:** The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

So that I know that you have read and understood these policies, please sign and print your name and write today's date on the line below. If therapy is for a minor child, please provide the signatures of legal guardians.

_____	_____	_____
Date	Signature	Print Name