Dr. Corrine McIntosh Sako, PsyD, LMFT
Clinical Psychologist • PSY 31218
Licensed Marriage & Family Therapist • LMFT 43424
1300 Ethan Way, Suite 170 • Sacramento, CA 95825 • (916) 202-1890

OFFICE POLICIES, GENERAL INFORMATION, INFORMED CONSENT FOR PSYCHOTHERAPY, AND AGREEMENT FOR PSYCHOTHERAPY SERVICES

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.

WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW: Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to me that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by me. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless s/he is authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client.

EMERGENCY: If there is an emergency during therapy, or in the future after termination, where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the biographical sheet.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct me, only the minimum necessary information will be communicated to the carrier. I have no control over, or knowledge of, what insurance companies do with the information s/he submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to hacking and unauthorized access. Medical data has also been reported to have been legally accessed by law enforcement and other agencies, which also puts you in a vulnerable position.

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fee of $175.00 per 45 minute individual session by the end of each session unless other arrangements have been made. Telephone conversations, site visits, writing and reading of reports, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify me if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. If requested, I will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement, if you so choose. As was indicated in the section, Health Insurance & Confidentiality of Records, be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. I have no control over, or knowledge of, what insurance companies do with the information I submit or who has access to this information. Not all issues/conditions/problems, which are dealt with in psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, I can use legal or other means (courts, collection agencies, etc.) to obtain payment. There is a $25 fee for returned checks.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement and my need to hire an attorney for consultation, I charge $350 per hour for preparation and attendance at any legal proceeding.

LITIGATION LIMITATION: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

CONSULTATION: I consult regularly with other professionals regarding my clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained.

E–MAILS, CELL PHONES, COMPUTERS, AND FAXES: It is very important to be aware that computers and email communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Faxes can easily be sent erroneously to the wrong address. Emails, in particular, are vulnerable to unauthorized access due to the fact that Internet servers have unlimited and direct access to all emails that go through them. It is important that you be aware that emails, faxes, and important texts are part of the medical records. Additionally, my emails are not encrypted. If you communicate confidential or private information via email, I will assume that you have made an informed decision, will view it as your agreement to take the

risk that such communication may be intercepted, and will honor your desire to communicate on such matters via email. Please do not use email or faxes for emergencies.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please leave a message at (916) 202-1890 and I will return your call as soon as possible. I check my messages a few times during the daytime only (on business days), unless I am out of town. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away, call the 988 Suicide and Crisis Lifeline at '988' or the Sacramento County Mental Health Urgent Care Clinic at (916) 520-2460. *Please do not use email, text messages, or faxes for emergencies.*

SOCIAL NETWORKING AND INTERNET SEARCHES: My practice has a professional page on Facebook and Instagram that you are welcome to follow. These pages are for marketing and educational purposes only, and they are not a substitute for psychotherapy.
I do not accept friend requests on social networking sites from current or former clients.
I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites.

RECORDS AND YOUR RIGHT TO REVIEW THEM: Both the law and the standards of my profession require that I keep appropriate treatment records. Unless otherwise agreed to be necessary, I retain clinical records only as long as is mandated by California law. If you have concerns regarding the treatment records, please discuss them with me. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. Upon your request, if it is appropriate, I will release information to any agency/person you specify in writing unless I assess that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

MEDIATION & ARBITRATION: All disputes arising out of, or in relation to, this agreement to provide psychotherapy services shall first be referred to mediation before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of me and the client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Sacramento County, CA in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, I can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum as and for attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and

resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. I will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. I may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, I am likely to draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches include, but are not limited to, psychodynamic, interpersonal, cognitive-behavioral, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational.

I do not provide custody evaluation recommendation, nor medication, nor medical or legal advice, as these activities do not fall within my scope of practice.

TREATMENT PLANS: For our first few sessions, we will be discussing a lot of basic information and doing some history-gathering. Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. In your treatment plan, we can list the areas you want to work on, the goals, the time, and other components. From time to time, we will review your goals and progress. If we think there is a need, we can change your treatment plan and/or its methods. If you have any questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask. You also have the right to ask about other treatments for your condition and their risks and benefits.

TERMINATION: As set forth above, after the first couple of meetings, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals whom you can contact. If at any point during psychotherapy, I assess that I am not effective in helping you reach the therapeutic goals or that you are non-compliant, I am obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, I would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition. If, at any time, you want another professional's opinion or wish to consult with another therapist, I will assist you with referrals, and, if I have your written

consent, I will provide her or him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, and if appropriate, I will offer to provide you with names of other qualified professionals.

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for rescheduling or canceling an appointment. Unless we reach a different agreement, the regular fee of $175.00 will be charged for sessions missed without such notification. Insurance companies do not reimburse for missed sessions.

LATENESS: If you are going to be late for an appointment, please notify me immediately. If you are 15 minutes or more late for a scheduled appointment, your appointment will be cancelled and you will be billed the full fee for the appointment (unless there are extraordinary circumstances).

UNEXPECTED THERAPIST ABSENCE: In the event of my unplanned absence from practice, whether due to injury, illness, death, or any other reason, I maintain a detailed Professional Will with instructions for an Executor to inform you of my status and ensure your continued care in accordance with your needs. *Please let me know if you would like the names of my Executor and Secondary Executor.* You authorize the Executor and Secondary Executor to access your treatment and financial records only in accordance with the terms of my Professional Will, and only in the event that I experience an event that has caused or is likely to cause a significant unplanned absence from practice.

I certify that I (or my dependent) have insurance coverage with the identified agency and assign directly to all benefits, if any, directly payable to Corrine McIntosh Sako, PsyD, LMFT for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize Corrine McIntosh Sako, PsyD, LMFT to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I have read the above Office Policies, General Information, Informed Consent for Psychotherapy and Agreement for Psychotherapy Services carefully (a total of 5 pages); I understand them and agree to comply with them:

Client's Name (print)	Signature	Date
Client's Name (print)	Signature	Date
Guardian/Parent Name (print)	Signature	Date
Dr. Corrine McIntosh Sako, PsyD, LMFT		
Therapist Name (print)	Signature	Date