ROOTS & anchors
PERIPARTUM COUNSELING

Krisztina Dihen M.S. LMFT

INFORMED CONSENT CONTRACT

Welcome to my practice.

This document contains important information about my professional services and business policies and how they may affect you. Please read it carefully and make note of any questions you want to discuss with me. Once you sign this document, it will become a binding agreement between us, providing your consent for us to begin therapy.

Therapy is a unique and highly individual experience with the outcome determined by the effort and motivation you bring to work towards a change in yourself and how you see the world around you. It can result in a number of benefits through challenging and changing beliefs, attitudes and behaviors. Therapy also has the potential to help you gain new understanding about yourself and learn new ways of coping with and solving them.

However, there is no guarantee that therapy will yield positive or intended results. Because feelings will be explored, you may feel a range of emotions that can be intense and uncomfortable at times. I encourage you to explore those feelings during our sessions, as they are part of the therapeutic process. My goal is to help you gain insight, awareness and management around the peripartum process and ultimatelly feel better.

Our therapeutic relationship is strictly voluntary. At any time during our work together, you have the right to decide to stop treatment. If you are thinking about ending I encourage you to discuss it with me, and if you wish, I will be glad to provide you with the names of other mental health providers. During the course of therapy, if I assess that I am either unable or not effective in helping you reach your therapeutic goals, I will discuss this with you. At times you might benefit of adjunct treatment, a higher level of care or a different therapist. I will provide you with appropriate referrals and assist you in the transition if you so desire.

Meetings

Each session lasts 60 minutes and will begin at the time agreed with you. Typically, therapy sessions take place on a weekly or biweekly basis, at a mutually agreed time. This can vary depending on your specific needs.

Cancellations and Rescheduling
If you need to **cancel or reschedule** a meeting, please notify me by telephoning my office **at least 24 hours in advance** of our scheduled meeting **or you will be responsible for full payment for the session.**
Keep in mind that insurance companies do not reimburse you for a missed session or a late cancellation.

Fees and Payment
Your session fee is $ 250.00 fir initial intake lasting 1.5 hrs. Subsequent session are 190.00. for a full hour. Payment of this fee needs to be made at the beginning of each session in full. Please have payment ready so that we can maximize your therapy time. I accept credit cards, checks (payable to Krisztina Dihen), cash or Venmo. In the event of any fee changes, you will be notified at least 30 days prior to such changes.

If you wish to seek reimbursement for my services from your health insurance company, please contact your insurance company to find out their limits of coverage for mental health services.
On my part I will give you a master bill for services you received from me for you to submit. Insurance companies vary greatly in their coverage of psychotherapy services, so check your policy to make sure that services provided by a licensed Marriage & Family Therapist are covered. You will also want to determine limits of reimbursement and deductibles. If carrier requires a diagnostic code, I will discuss my diagnosis with you.

Additional Fees
Extended sessions and telephone conversations that exceed ten minutes will be charged a fee based on your regular session fee. Written reports, evaluations authorized or requested by you, or copying of your file follow this same policy.

Contacting me
You may contact me at (415) 420-9029 Monday through Friday until 5pm. I will try my best to reach you within 24 hours of your phone call. I am not available on weekends or holidays.

Email Usage

By nature, therapy is confidential. You can have the confidence that your insights, vulnerable experiences, and feelings will not be repeated outside the therapeutic relationship established.

By nature, email correspondence is NOT confidential. Though Internet security measures can be effective, it is never 100% seal proof.
My policy regarding email usage is as follows:

- Email correspondence with me is NOT secure.
- Email correspondence is NOT a substitute for person-to-person therapeutic treatment, unless discussed with me in advance and in person.
- Most things stated in an email from you will be discussed in session, and in session only.
- Email correspondence is NOT to be used in the case of an emergency to contact me.
- If you need to contact me with something that demands attention of a 24 hour turn around period, you may do so by voicemail at the following number: **415-420-9029**
- **In case of an emergency call 911, or go to the emergency room.**

Emergencies
If you are experiencing a life-threatening emergency and need to talk to someone immediately, you can call 911, the Suicide Prevention Hotline at (800) 273-TALK (8255), the police, or your local hospital emergency room. I advise that you go to the nearest emergency room if you are not feeling safe and/or your child is not safe. I will follow up with you and your providers to help you make a plan around establishing safety and receiving necessary treatment.

If you have any questions about you're your medication(s) please contact your prescribing provider.

Confidentiality
Everything you say and share in session is strictly confidential. However, there are some exceptions to the rule of confidentiality.
I am required by law to report:

- threats of harm to another or oneself
- suspected child or elder abuse (past or present)
- by court order

Other exceptions include:

- per your signed release

- If you would like give me permission to discuss your case with someone (family member, other supports, midwife, doula, etc) you can sign a ROI (Release of Information before or during our first session)

I may discuss your case with peer counselors in order to provide excellence in the service I give and in accordance with ethical professional behavior. In doing so, I will keep your identity or any details allowing your identification confidential.

Agreement

I understand that the mode of peripartum therapy delivery will be through outreach and in my home.

I understand that the reason for this is to deliver assessment, therapy, skill building and other resources in a way that is comfortable, accessible and comforting during the peripartum period.

I have read this information fully and completely, I have discussed any questions I had about the information, and I understand the information. I acknowledge that it is my choice to participate in psychotherapy.

I realize that the outcome of therapy depends upon my personal investment in the therapy process. I have familiarized myself with the fees and charges for services provided by Krisztina Dihen, M.S., M.F.T., and I understand and agree that the therapeutic services rendered will be charged to me and not to any third-party payer. I acknowledge responsibility for payment of these services.

Signature of Client Date

_____ _____

Signature of Client (Partner) Date

_____ _____

Signature of Support – Relationship: Date

_____ _____

Signature of Therapist Date