LMFT9712
suebushrowmfti@gmail.com
FAX: 951-693-3366

Sue M. Bushrow LMFT
Licensed Marriage & Family Therapist

43385 Business Park Dr. Suite 100
Temecula Ca. 92590
951.249.3774

Treatment Agreement

The above named therapist and I have discussed my/my child's case and I have been informed of the risks, approximate length of treatment, alternative methods of treatment, and possible consequences of the decided treatment. I have been informed that the therapist primarily uses psychodynamic therapy, brief cognitive therapy, solution focused therapy, and play & expressive arts therapy.

Therapeutic services are provided for the purpose of

- **stabilization,**
- **decrease & relief from symptomology,**
- **to improve coping, problem solving & use of resources,**
- **behavioral modification & cognitive restructuring,**
- **skill development,**
- **grief resolution,**
- **stress management,**
- **improving communication skills,**
- **relationship development**
- **learning new parenting skills**

- While I expect benefits from this treatment, I fully understand and accept that because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed.
- I understand that the therapist does provide emergency services and I have been informed of whom/where to call in an ***emergency*** during evening and weekend hours. That emergency cell number is 951-249-3774. For life threatening emergencies, dial '911' or proceed to the nearest hospital emergency room.
- I understand that regular attendance and completion of outside homework assignments between sessions will produce the maximum possible benefits.
- I understand that I can discontinue treatment at anytime in accordance with the policies of this office.
- I understand that I am financially responsible for the prearranged fees for service of ____per session. I also understand that phone consultations lasting longer than 5 minutes will be billed to the client on a prorated basis.
- I understand that a **charge of $85** will be made for any session canceled less than 24 hours in advance of said appointment regardless of the reason for that cancelation. This includes times when I fail to show up for your appointment at the prearranged time.
- I understand that session fees charged are for a scheduled 50 minute session (45-50 minute sessions are standard to the profession).
- I understand that there is a fee charged for the therapist to attend any IEP or SST meeting, said fee based upon time required for preparation for the meeting, the meeting itself and travel time to and from the meeting place.
- I understand there is a fee charged for any letters or reports made at my request or for time required for Court appearances. These charges are based upon the time required to complete the task including travel time.
- I have been informed and understand the limits of confidentiality and that by law, the therapist must report to the appropriate authorities any suspected child abuse/neglect, elder abuse/neglect, or serious threats of harm to myself or another person.
- I am not aware of any reason why I/my child should not proceed with therapy and I/we agree to participate fully and voluntarily.
- I can discuss the aspects of treatment fully, I can expect my questions to be answered, and I can provide input for the development of treatment goals.

Therefore, I agree to comply with treatment and authorize the above named clinician to administer the treatment to me/my child.

Name of client (please print): _____ Date of Birth: _____

Signature of Client/Legal Guardian: _____ Date: _____

Form 3

LMFT97127
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FAX: 951-693-3366

Sue M. Bushrow LMFT
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43385 Business Park Dr. Suite 100
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951.249.3774

CLIENT COPY / Treatment Agreement

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- I understand that a **charge of $80** will be made for any session canceled less than 24 hours in advance of said appointment regardless of the reason for that cancelation. This includes times when I fail to show up for your appointment at the prearranged time.
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Please keep this copy for your records.