Disclosure Statement

Terri Phillips, MA, MFT
32605 Temecula Parkway #208
Temecula, Ca 92592
www.terriphillipsmft.com
terri@terriphillipsmft.com
Phone: 909 730-0410
Fax: 951 742-4843

Education/Degrees

M.A. Masters of Arts in Counseling Psychology: La Jolla University: 1992
B.A. Bachelor of Arts in Psychology: Trinity International University: 1983

Registrations

Licensed Marriage and Family Therapist
California License Number: MFC33153
Member of CAMFT (California Association of Marriage and Family Therapists)
Affiliate of EEG Spectrum International (Neurofeedback Training Organization)

Department of Regulatory Agencies

The California State Department of Regulatory Agencies regulates the practice of both licensed and unlicensed persons in the field of psychotherapy, their contact information is provided below. Concerns or complaints regarding the practice of psychotherapy may be directed to the State of California Department of Consumer Affairs, Board of Behavioral Sciences,1625 North Market Blvd. Suite S-200, Sacramento, Ca 95834; (916) 574-7830.

Client Information & Rights

- You are ENTITLED to receive information from Terri Phillips, MA, MFT regarding methods of therapy, the techniques used, duration (if known) and fee structure. You have the right to seek a second opinion or terminate therapy at any time.
- The information provided by the client during counseling is legally confidential except for certain legal exceptions. Exceptions to the rule of confidentiality will be identified to you should any such situation arise during therapy, if practical. Examples of such exceptions are when the client is an imminent danger to self or others, or when there is suspected child abuse or neglect. Exceptions to the general rule of legal confidentiality are listed in the California Revised Statute.
- Sexual intimacy between a client and therapist is never appropriate and should be reported to the governing board immediately.

Consent for Treatment and Financial Agreement

I voluntarily consent to participate in mental health and/or Neurofeedback and/or consultation services with Terri Phillips, MA, MFT. Please review the rates for the following services:

- Individual, Child/Adolescent, Family, Couples Treatment, Consultation by Phone: $125.00 (50 Minute Hour)
- Emergency or After Hours Consultation: $140.00 (50 Minute Hour)
- Professional/Business Consultation: $150.00 (50 Minute Hour)
- Neurofeedback: $80 per session (30 Minute Session). Special session packages available if paid for in advance (see rate sheet).

***If you are currently receiving a rate reduction, which has been previously arranged please enter this hourly rate here: _____. This corresponds to a _____ % discount.**

- Therapy Partner Corporation is outsourced billing agency utilized by Terri Phillips, MA, MFT. Therapy Partner Corporation will manage all administrative and billing functions associated with the practice. This will allow the practice to continue to focus on service oriented tasks aimed at ensuring quality care. Payment for your treatment will be electronically deducted from a designated checking/savings, or debit/credit card account at the time of service. Visa, MC, American Express and Discover cards will be accepted. Please see Electronic Payment Authorization Form.
- Insurance billing and office work may be outsourced by a third party vendor.
- I understand that I am responsible for payment at the time services are rendered. I agree to give at least 24 hours notice in the event I need to cancel an appointment. If I fail to give such notice, **I understand that I will be charged a full session late cancellation fee**. **I understand that if I fail to call and do not show up for an appointment I will also be charged the full fee for that session.**
- I understand that my insurance company will not be billed for cancelled or missed appointments.
- If a report, letter or consultation by an outside party is requested, I understand that I will be billed the usual hourly rate for the time needed to prepare the document, or to conduct an in person or phone consultation.
- Any bill not paid within thirty days will be assessed a service charge at the rate of 1.5% per month. Returned checks will be charged a $25.00 service fee. In the event that billing efforts fail, delinquent accounts will be subject to Collections Recovery at the discretion of Terri Phillips, MA, MFT. Additionally, an attempt will be made by Terri Phillips, MA, MFT to develop a payment plan with clientele who wish to seek this option for outstanding balances. By signing this agreement you are agreeing to this procedure.

If there is a life endangering emergency, please call 911/ go to the nearest emergency room. Urgent and after hour phone calls will be picked up daily.

Terri Phillips, MA, MFT is currently renting office space from other treatment providers. You should be aware that other than renting office space, there is no other relationship between Terri Phillips, MA, MFT and the other treatment providers. They are all in their own separate practices; they do not supervise one another; they are not in a partnership; and they have no responsibility for each other's practice.

Signature Form

1. **I understand and agree to the Disclosure Statement, Consent for Treatment and Financial Agreement.**
2. **I have also been informed of my therapist's degrees, credentials and licenses. I have read the preceding information and have been informed and understand my rights as a client.**

Client Signature:_____ Date:_____

Client Signature:_____ Date:_____
(Parent or Guardian if client is a minor)

Informed Consent or Neurofeedback Training

I hereby authorize ***Terri Phillips, MA, MFT*** to provide me with neurofeedback training.

I understand that this training is used for a variety of conditions which appear to be associated with irregular brain activity, including but not limited to ADHD, OCD, depression, anxiety, stroke and seizure disorders. Training is recommended on the basis of empirical observation of improvement in clients with similar conditions.

I understand that EEG biofeedback (neurofeedback) requires placement of surface electrodes on my scalp for the purpose of recording my EEG and the use of this signal to provide video displays and audio signals.

I understand that some individuals have reported that training may affect my body's response to medications for my conditions and for unrealated conditions. I understand that I should not stop or alter any of my medications without consulting my physician/psychiatrist. I should continue ongoing therapies until otherwise advised by the physician. Should new symptoms develop, it is my responsibility to inform my health care providers including my neurofeedback practitioner.

I understand that it is the client's own responsibility to monitor the subjective effects of training. Neurofeedback is based on the input of the client's report from day to day sessions as well as from the initial evaluation and depends on the full participation of the client by his/her feedback about the effects of the training. The research literature indicates that there are some individuals who are apparently unaffected by training. Accordingly, the client is encouraged to evaluate progress after about ten sessions to determine if further training is indicated. Discussion is invidted at this point or any time during treatment.

No representation is made that any individual client will improve from training. There is some indication that some clients improvement may fall off after cessation of training. These individuals would benefit from

periodic follow-up or booster sessions. This training is non-invasive and appears to be a harmless procedure as far as is know at present. No injuries are know or reported in literature.

By signing this form, I indicate my understanding of the principles set forth here and waive any claim of damages due to the training including worsening of my condition for which the training was undertaken, claimed side effects of the failure to improve with training. I agree to submit any dispute with ***Terri Phillips, MA, MFT*** to binding arbitration under the rules of the American Arbitration Association.

Signature_____ Date_____

Printed Name_____

Consent for Treatment of Minor

By signing I consent for the above treatment of Neurofeedback training provided by ***Terri Phillips, MA, MFT*** for my minor child. I affirm that I am the parent or legal guardian authorized to make decisions for the following child.

Child's Name_____ Date of Birth_____

Parents Signature_____

Release of Information

I agree that ***Terri Phillips, MA, MFT*** may consult with the client's primary care practitioner _____
Or specialist_____
With regard to the neurofeedback training and obtained results.

Signed_____ Date_____

Printed Name_____

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