

CRISTY PARETI, PsyD, LMFT
Licensed Marriage and Family Therapist MFC #47538
616 S. El Camino Real #9-G
San Clemente, CA 92672
Telephone: (949) 302-9182
Fax: (949) 420-2184

OFFICE POLICIES

Cancellation Policy: A 24-hour notice is required since this is a reserved time for you. The full fee will be charged for missed appointments without a 24-hour notification. If utilizing your health insurance, please be aware that insurance companies do not typically reimburse for missed sessions.

Confidentiality: The therapist and client relationship is held in strict confidentiality unless:

- 1) You present a danger to yourself or others;
- 2) You authorize a release of information with your consent and signature; and/or
- 3) Child or elder abuse is suspected.

If you are a danger to yourself or others or if there is suspected elder or child abuse, we are legally required to inform the appropriate legal authorities and/or potential victims, so that protective measures can be taken.

Phone Consultation: You can call, if needed, between sessions. Please leave a message with your phone number. Be aware that I generally return phone calls within four (4) hours. I may not be able to return calls immediately as I will be in session. Please be advised that calls that exceed 10 minutes will be considered a counseling session and will be charged accordingly.

Fees: Full payment is due at the beginning of each session*.

Individual psychotherapy session:	50-55 minutes:	\$150 or _____
Individual psychotherapy session:	75-90 minutes:	\$225 or _____
Couples psychotherapy session:	50-55 minutes:	\$185 or _____
Couples psychotherapy session:	75-80 minutes:	\$230 or _____
Family psychotherapy session:	75-80 minutes:	\$185 or _____

*Fees are also available on a sliding scale.

If you decide to utilize your insurance, it will be necessary for me to verify your health insurance coverage, both which type of policy you have and what they reimburse for mental health care coverage for either in-network or out-of-network providers. You have the option for me to proceed with billing your insurance company. I will bill for out-of-network coverage. You are responsible for your deductibles and any co-insurance.

Consent for Treatment: I further authorize and request that Cristy Pareti, PsyD, LMFT, carry out assessments, treatment and/or diagnostic procedures which now or during the course of my care as a patient, are advisable.

Patient Name: (print) _____

Patient: (signature) _____

Date: _____