Judy Moore, MFT
140 B St. #256, Davis, CA95616
(530) 574-3657
judymooremft@gmail.com

CLIENT TREATMENT AGREEMENT

Welcome to my practice. I appreciate your trust and the opportunity to be of service to you.

CONSENT TO TREATMENT: I, _____(Client or legal Guardians) authorize Judy Moore, MFT to provide psychological services to me or my dependents _____ _____ in sessions that last 50 minutes from the scheduled time. I understand that while the course of treatment is designed to be helpful, that no practitioner can make a guarantee of positive outcome from the treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness and anger. I understand that this is a normal response and a precondition to working through unresolved life experiences.

CONFIDENTIALITY: is a promise to reveal nothing about you or your situation while you are in treatment with me. Children and teenagers have confidentiality when they are working with me. Before I share any information outside of session I will get your permission in writing. I do consult regularly with other therapists in order to become a better therapist and should I discuss your case, I will not reveal your name or any identifying information.

There are four situations where I will not keep what you tell me confidential or secret:

1) If you tell me about child abuse, including physical, sexual abuse, or neglect, because I am a mandated reporter. I also must report elder abuse or the abuse of a dependent adult.
2) If you tell me you are going to hurt yourself or hurt someone else
3) If a judge orders the disclosure
4) In transactions with your insurance company in regard to collection of fees owed.

COURT: If you ever become involved in a court matter, including but not limited to a divorce, custody dispute, lawsuit, workman's comp claim, etc. please be aware that I do not provide information such as letters to or reports for the court. I do not make custody recommendations.

FINANCIAL AGREEMENT &TERMS OF PAYMENT: I agree to pay Judy Moore $150_____ or $_____co-payment per session according to my insurance plan. Payment will be made at the time of each session. **I understand that if authorization has been denied or if I am ineligible for insurance benefits, I agree to pay all agreed upon charges in full.** I assign all insurance benefits to which I am entitled to **Judith Moore, MFT** and authorize Judy Moore to release any information necessary to transact normal business with my insurance company. I realize that I am responsible for all charges not paid for by my insurance according to Judy Moore's contractual agreements with the insurance company. I understand that my scheduled appointment is a time that is specifically reserved for me. **I agree to pay $150 for all appointments that I fail or cancel with less than 24 hours notice.** I understand that in the course of doing business, Judy Moore may have to cancel or change the time or day of your appointment as necessary. I understand that there will be no charge or any credit to my account for such cancellations.

Due to Covid 19 all sessions are now conducted by Zoom, Facetime or cell phone.

AGREEMENT: I have read and understand the above and agree with my obligations according to it. I understand that I will receive a copy of this contract/agreement if requested.

Date	**Client Signature**
Date	**Client Signature**