Marlon A Guarino, MA

Licensed Marriage & Family Therapist #109822
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831) 316-4827
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CONFIDENTIALITY: The information shared with a psychotherapist is confidential and law protects this confidentiality. Authorizations for release of information must be in writing. However, there are some legal exclusions to confidentiality, which are listed below.

1) When a person is a danger to self
2) When a person is a danger to others
3) Upon receipt of a valid court order
4) Where **suspicion** of child abuse exits
5) Where knowledge of elder or dependent abuse exits.

_____ **APPOINTMENTS:** Appointments are scheduled to last 55 minutes, or 80 minutes, dependent upon your preference and/or what your insurance will allow(if you are using insurance). Consistent attendance is encouraged in order that you receive maximum benefit from your therapy. Your weekly appointment time is reserved for you, and charges begin from the scheduled appointment time whether you are punctual, late or absent.

_____ **CANCELLATION POLICY:** If you want to avoid charges for late cancellations and missed appointments, **please phone (831) 316-4827 at least 48 hours ahead to avoid full payment for time reserved.** Late cancellations will be charged in full. No cancellation charge in case of an emergency, illness, or if the time slot can be filled.

_____ **FEES:** All charges are payable at the beginning of each office visit or by specific agreement with me. My fee may increase periodically and you will be given a one-month notice of any change. Cash or check is accepted.

_____ **HEALTH INSURANCE:** Your office visits may be partially covered by mental health provisions in your policy. Please feel free to discuss the type of information insurance providers require prior to making your decision. **My contract is with you and you are responsible for payment.**

Name: (Print): _____ Birth Date: _____Today's Date:_____

Address: Street _____ City_____ State _____ Zip_____

Email:_____ messages ok?___

Phone: home:_____ work: _____ cell: _____ Text ok? ___ Voice msg ok?___

Have you ever been hospitalized for psychiatric or emotional reasons overnight? _____
Are you taking any psychiatric prescriptions? _____

Use MediCal? __ Member Id #:_____

Emergency Contact: Name:_____Relationship:_____Phone:_____

Client Signature:_____

Therapist Signature: _____
Marlon A Guarino

SIGNATURE ON FILE FOR THE RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

Insurance: *Your signature is required if you wish our office to be of service to you in billing your insurance company. Should we not receive this signed authorization, we cannot bill your insurance company for you and you will have to bill your insurance directly*.
I understand that I am responsible for the deductible and non-covered services. I understand that my insurance policy may have certain limitations on mental health benefits. I agree to accept full responsibility for charges once these limitations have been reached. I further agree to accept full financial responsibility for payment of charges rendered to the above-named patient.

Release of Information: I authorize the release of any medical or other information necessary to process this claim.

Assignment of Benefits: I authorize payment of medical benefits from my insurance company for health services provided. I permit a copy of this authorization to be used in place of the original.

Client's Signature: _____ Date_____