Sophie Soltani, PsyD
2171 Shattuck Avenue Berkeley, CA 94704 **Phone: (510) 523-4300**
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FEE
The fee for each session is $_____and is due at the start of each session.

TIME
Each **session is 50 minutes** in length unless otherwise is agreed upon. If the client is late only the remaining time will be available.

CANCELLATION
As each session is scheduled exclusively for the client, **the client will be charged at the regular rate for no-show or same day cancellation.** If the cancellation occurs within 48 hours, I will attempt to schedule the client for another available appointment time.

TELEPHONE CONTACTS AND EMERGENCIES
Please reserve telephone contacts for cancellation, reschedules and emergencies.
If in an emergency, you have a therapy session with me over the telephone and fine that you need to talk more than 10 minutes, you will be charged the regular, agreed-upon fee. The fee will be prorated, if you talk for less than 50 minutes with me. In case of an emergency, you may wish to contact a backup therapist whose name will be given to you. Fee arrangements for emergency sessions should be made with that person. Alternatives include contacting 911 or Crisis Support Serves at **800-309-2131**.

CONFIDENTIALITY
All information between the client and psychologist is held strictly confidential.

EXCEPTIONS

1. The client presents danger to self or others.
2. Child physical, mental abuse or neglect is suspected.
3. Elder (65 years or older) abuse is suspected.
4. The client authorizes the release of information.
5. The psychologist is ordered by a court of law to release information.

Clinical information will be disclosed to your insurance company as needed for coordination of services, quality assurance and/or payment, via mail, fax, or electronically.

INSURANCE
Since insurance companies do not reimburse for the following, you are responsible for the agreed-upon fee in these cases: 1) no-show 2) last-minute cancellations 3) emergency telephone sessions 4) telephone calls to other professionals or family members 5) summary reports for courts, etc. By signing below, you are authorizing direct payment to me by your insurance company. You are also authorizing me to disclose relevant information about your treatment to your insurance company, as required. Clinical information will be disclosed to your insurance company as needed for coordination of services, quality assurance and/or payment, via mail, fax, or electronically. Lastly, if your insurance company refuses payment, you are responsible for all fees.

FREQUENCY
The depth and effectiveness of psychotherapy requires consistency, dedication, and attention. At the beginning, the individual and couples meet with the psychologist once a week. As the work progresses and a need is assessed, the sessions may be held twice a week. However, these decisions will be discussed in depth with the client.

I have reviewed and understand the information furnished above.

_____ _____
Client's Signature Date Sophie Soltani, PsyD Date