*Licensed Marriage & Family Therapist Associate (#MG 60583510)*

[www.franciscobujanda.com](http://www.franciscobujanda.com) ​­ (360) 436­6298

**Practice Policies**

**Appointments & Cancelations:**

***Session Length​:*** All typical individual sessions are 55 minutes long. Couples sessions are schedule between 55-85 minutes long. Longer or shorter sessions may be scheduled in advance with additional fees. It is up to you, however, to determine the length of time of your sessions. Requests for additional time or changes need to be discussed with the therapist in order for time to be scheduled in advance.

***Scheduling:*** I schedule clients at the end of every session or over email correspondence. Please email me for new appointments or for purposes of rescheduling.

***Cancelations:***Please remember to cancel or reschedule 24 hours in advance. You will be responsible and subject to the full session fee if cancellation is NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary as a time commitment is made to you and the time is held exclusively for you. If you are late for a session, you may lose some of that session time.

**Fees​:**

* I operate my practice on a self-pay model. At the end of each session, the client is responsible for payment for the agreed upon rate. Individual sessions with the duration of 55 minutes are $100. Couple and family sessions are $125 for a session length between 55-85 minutes. I offer a limited number of sliding scale fees for clients.
* I accept cash, check, credit card, Apple pay, or Android Pay. If you wish to pay via credit card or contactless means, an additional 2.83% transaction fee will be applied. If seeking to pay with check, please have it made out to ‘Francisco Bujanda’ before the start of each session.
* I do not accept insurance. You can submit for reimbursement from your insurance company if your insurance plan covers “out-of-network” providers. Please, let me know if you are seeking to do this in order to provide you with a ‘Superbill of services’ rendered. I typically complete these for clients quarterly.
* A $10.00 service charge will be charged for any checks returned for any reason for special handling. If you have any concerns regarding finances, please feel free to ask.

***A note about gifts​:*** I cannot accept any form of financial or material gifts as a therapist, no matter how small. It goes against my professional code of ethics.

**Telephone Accessibility:**
If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that Face- to-face sessions are highly preferable to phone or Skype sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911 or any local emergency room.

**Social Media & Telecommunication:**

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

**Electronic Communication**:
I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. If you and I, as your therapist, chose to use information technology for some or all of your treatment, you need to understand that:

1. You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
2. All existing confidentiality protections are equally applicable.
3. Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.
4. Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.
5. There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist’s inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what they, she, or he would consider important information, that you may not recognize as significant to present verbally the therapist.

**Termination:**Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

**Unprofessional Conduct​:**

I encourage clients to speak with me directly if they are dissatisfied with my services, or would like to be referred to another mental health professional, or would like to cease therapy. Clients have the right to contact the Washington State Department of Health if they believe that I have broken ethical guidelines to file a complaint. You can reach the

*Department of Health, Health Professions Quality Assurance* at (360) 236­4700, P.O. Box 47857 Olympia, WA 98504, or at their website: <http://www.doh.wa.gove/hsqa/HealthProfComp.htm>

***By signing below I agree that I have received, read, and understand the Practice Policies, as well as agree to its terms stated herein.***

Client Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_