CLIENT AGREEMENT & INFORMED CONSENT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us. If you decide that you do not wish to consent to these services and policies and, therefore, would not like to proceed with services here, there will be no charge for our meeting today.

CLIENT AGREEMENT & INFORMED CONSENT

I ask that you review, and sign this document where shown. Successful therapy requires a commitment by both the therapist and the client. The following policies have been established for my private practice.

Please sign at the bottom showing that you agree, acknowledge, and/or understand:

PRIVACY NOTICE:

By signing below I acknowledge that you have received and read the Notice of Privacy Practices document explaining confidentiality and the limits of privacy. You understand that if you have questions about privacy or the Privacy Notice, the best time to ask them is at the beginning of the first session

Your medical records are used to provide treatment, bill and receive payments, and conduct healthcare operations. Examples of these activities include but are not limited to review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder telephone calls, and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal used outlined above except required by law or authorized by the patient or legal Federal and State laws require abuse, neglect, domestic violence, and threats to be reported to social services or other protective agencies. If such reports are made they will be disclosed to you or your legal representative unless disclosure increases the risk of further harm.

You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want to be disclosed, the name and address of the entity you want the information released to, purpose, and the expiration date of the authorization. Any authorization provided may be revoked in writing at any time. Psychotherapy notes are part of your medical records. We have 30 days to respond to a disclosure request and 60 days if the records are stored off-site.

You may request corrections to your records.

A request for disclosure may be denied under the following circumstances: the disclosure would likely endanger the life or physical safety of you or another person, requested information references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.

If a request for disclosure is denied for reasons outlined in Section 6, you or your legal representative may request a review of the denial. A review will be conducted by another licensed healthcare provider appointed by the original reviewer, who was not involved in the original decision to deny access. A review will be concluded within 30 days.

You may request that we restrict uses and disclosures outlined in Section 1. However, we are not required to agree to the restrictions. If an agreement is made to restrict use or disclosure, we will be bound by such restriction until revoked by you or your legal representative orally or in writing except when disclosure is required by law or in an emergency. We may also revoke such restrictions but information gathered while required by law or in an emergency. We may also revoke such restrictions but information gathered while the restriction was in place will remain restricted by such an agreement.

If you wish to complain about privacy-related issues you may contact info@2PointPerspective.org. In any case, there will not be any retaliation against you or your legal representative for filing a complaint.

Understanding Psychotherapy Services:

A therapist helps clients with mental, emotional, cognitive, and behavioral difficulties. Psychotherapy is intended to help you reach a better understanding of specific problems or increase self-awareness. It is also intended to work toward improvement of the identified problems, offer support in problem-solving, provide some symptom relief, and improve in coping with daily life activities. Your progress in psychotherapy and its outcome depends upon many factors including but not limited to your level of motivation and desire to change, the effort that you put forth in following through with agreed-upon therapeutic tasks outside of session, keeping your appointments, and your willingness to be open with me as we work together.

***Therapy may have both risks and benefits*.** It often involves discussing difficult or unpleasant aspects of your life, and you may experience uncomfortable feelings about these discussions, such as sadness, guilt, anger, and frustration. Some of the changes you make as a result of psychotherapy may not be welcomed by other people in your life. This may result in some strain in your relationships with family and others. Therapy may disrupt a romantic relationship. Sometimes, it is also possible for a client's problems to worsen immediately after beginning therapy. Most of these risks are to be expected when people are making important changes in their lives.

On the other hand, research has shown that therapy may also be beneficial, leading to improvements in individual psychological health, communication and problem-solving skills, and relationship satisfaction. It is important to understand that there are no guarantees about what you may experience during therapy or how therapy may affect you.

I implement different strategies, methods, and interventions when working with a client tailored to their specific situation and goals. I may use elements of Cognitive Behavioral Therapy (CBT), solution-focused therapy, supportive client-centered therapy, and other methods during treatment. I may utilize specialized training to provide more specific treatment methods when appropriate and with your agreement and participation.

First Meeting or Initial Assessment

Our first session, and possibly the first few sessions, will involve an assessment of your therapy needs and goals. There are several possible outcomes of this initial assessment, as it is an opportunity for us to decide if working together may be beneficial for you.

Therapy Session and Attendance

If psychotherapy is begun, I will typically schedule therapy sessions (45-55 minutes in duration for one session) at a mutually agreeable interval. The length of the therapy session may depend on what is allowed by your insurance provider; some insurance providers approve a 45 min session. Together we will typically agree on specific goals for therapy, such as symptom reduction, behavioral change, improved communication and/or interpersonal skills, the ability to return to work or school, and I will prepare a written treatment plan. Goals will in all likelihood change as the therapy progresses and should be renegotiated accordingly. The therapeutic approach used will vary and should be discussed with me whenever you have questions or when you believe therapy is not helpful.

How long you remain in therapy and the frequency of sessions is a matter best discussed while we work together to achieve your goals. While it is your right to end therapy at any time, when you decide to end treatment, it is in your best interest to discuss this with me beforehand.

Professional Fees:

Keep in mind that the fees listed below are the total fees BEFORE discounts and benefits. You may NOT *be responsible for the entire fee if you are using a discount, insurance benefits, or other benefits. You may only be responsible for your co-pay, co-insurance, or deductible amount; or your benefits provider may pay the entire cost of these services.*

-Initial Evaluations: $150	-Individual and Family Therapy 30-45min $105	-Late Cancelation Fee $25
-Individual and Family Therapy $120	-No Show Fee $60	-Records Request $25

I, understand that my therapist has reserved time specifically for me and that I must call to cancel an appointment at least 24 hours in advance, or will incur a charge of $60.00. My session fee is $120.00 for 50-60minutes and $105 for 30-40minutes. Payment is expected at the time of service. You are responsible for the charges. If you are paying through your insurance, you are responsible for your co-pay at the time of service and for any amount left unpaid by your insurance.

Litigation Policy and Fees for Court-Related Services

I do not want to be involved in your litigation. I do not want to deal with subpoenas or lawyers or have to disclose your confidential information in court. I do not enjoy going to court and I do not want to deal with the negative feelings that can result from court or deposition testimony. The nature of the therapeutic process often involves making a full disclosure with regard to many matters which may be extremely private, upsetting, or embarrassing. If you become involved in any legal proceeding during your therapy with me, including but not limited to divorce and custody disputes, or personal injury lawsuits, you agree that neither you, nor your

attorneys, nor anyone acting on your behalf will subpoena records from my office, or subpoena me to testify in court, in a deposition or in any legal proceeding. By your signature below, you acknowledge my position and agree to abide by my litigation policy.

If you involve me in your litigation, or if you or your attorneys subpoena me to provide my records, testify in court or give a deposition in violation of this agreement and against my stated wishes, I will comply with lawfully issued subpoenas. My hourly charge for all time related to court cases or litigation is $300.00 per hour. You also agree by your signature below to execute and sign a Credit Card Authorization and provide a valid credit card to ensure payment for the time I must spend dealing with your litigation.

If I am subpoenaed to provide records or testimony in violation of this agreement and against my stated wishes, you also acknowledge and agree that you will pay for all of my professional time, including but not limited to preparation, record review, transportation charges (door-to-door), waiting time, and time spent testifying in court or deposition regardless of who issues the subpoena or requires me to testify.

SCOPE OF PRACTICE:

I will NOT perform social studies or custody evaluations. I will NOT provide recommendations regarding possession, custody, access to, or visitation with minor children. I will NOT provide medication or medical advice. I will NOT provide legal advice. These services are NOT within the scope of my practice.

Emergencies and Crisis Situations:

I am not a crisis counselor. I do not have the resources needed to quickly respond to a crisis or emergency. If you experience a life-threatening emergency, including suicidal thoughts, you should call 9-1-1 or go immediately to the nearest emergency room.

Contacting Me by Phone

Other than session attendance, the only way I may be contacted is by the office phone number. My office hours vary, and I am often not immediately available by telephone. For scheduling assistance, you may also dial 0 to speak with one of my staff members, they can often help you with scheduling quicker than contacting me.

While I prefer to keep clinical discussions to our scheduled appointment times, there may be times in which you need to contact me and discuss clinical matters over the phone. By initialing here and signing below you understand that I will charge for phone calls lasting longer than 10 minutes pro-rated at the $120.00 per hour rate; and these charges will not be billed to your insurance company. You understand that insurance benefit providers do not pay for phone (audio only) meetings, and those charges are solely your responsibility and you agree to pay for such charges at the agreed-upon rate.

Use of Electronic Communications:

I do have the capacity to use e-mail, text, and calls for delivering messages like session reminders however I do not use e-mail or text messages with clients regarding clinical matters. It is your responsibility to inform me of your preferred method of communication. If you need to discuss a clinical matter between sessions, please call me. If you choose not to respect my policy regarding e-mail and text communications,

I do not allow audiotaping of sessions unless we have agreed otherwise in advance and you have signed a specific written authorization for the taping to occur. By your signature below, you acknowledge that you understand my policy on the audio taping of sessions and you agree to abide by it.

I do not engage in communication or relationships via social media with clients. This is for the protection of your privacy as well as the therapy relationship. If you happen to encounter me by accident through social media or the internet, please feel free to discuss this with me in session.

I would never post information about a client on a public website. I ask that you respect my privacy and refrain from posting any "reviews" or other information regarding my practice or me on any website such as Health Grades, Angie's List, or another forum for posting public reviews of health care providers. By your signature below, you agree that you will not post any "review" or any other information on any website without my prior written permission. If I believe that you have violated this agreement, I reserve the right to terminate our professional relationship immediately and refer you to other mental health professionals.

CLIENT FINANCIAL RESPONSIBILITY:

You understand that the cost associated with therapy is due at the time of service and you agree to pay those costs at the time of service. You understand that you will not be rescheduled, and further services will be withheld if you do not meet your financial obligations. You understand that the cost at the time of service may not be correct due to missing, incomplete, or incorrect information, and you agree to pay any outstanding balances even after the services have been delivered if you did not meet your full financial obligation at the time of service.

Payments may be made with a personal check, money order, cash, credit card, or debit card with a credit card log. If you are paying with cash your provider will not be able to make the change and any overage will be applied as a credit to your account. Any returned check will be charged a $25.00 processing and return fee.

You agree that any "insufficient funds" fees charged to you by your financial or banking institution due to payments made to your therapist are NOT the responsibility of Two Point Perspective LLC.

Insurance or Benefit Changes:

You agree to immediately notify me when your insurance or EAP benefits change in any way. The best time to notify me is before the new benefits take effect. You understand that if your insurance changes your financial responsibility may change, and you agree to pay any differences in what was collected from you and what you owe due to a change in your benefits.

It is also understood that I am individually credentialed on specific insurance panels. If you switch to new insurance, I may not be on that panel, meaning I cannot bill them for services, and the full cost of services would be your sole responsibility. I am on most commercial insurance panels in this area, but you will need to check with me or my office staff to confirm.

Medicaid:

I am a provider of Medicaid. I will be able to bill some of these insurance providers if they are your primary insurance. However, it is your responsibility to communicate your insurance status with me. If you only give us your supplemental plan information, and claims are denied due to my non-participation in Medicaid, you will be responsible for those full fees out-of-pocket unless you have an agreement with Child Protective Services.

Appointment Reminders:

Our scheduling system will send you a courtesy reminder approximately 24 hours before your appointment. You understand that the courtesy reminder system is automated and prone to malfunction from time to time. You agree to pay the Late Cancelation or No-Show fee if you miss an appointment regardless of receiving the appointment reminder.

If we happen to encounter each other outside of the professional setting, I will not address you unless you address me first. This is for the protection of your privacy. I'm happy to return a friendly greeting but will allow you to take the initiative if you would prefer to do so.

LIMITS ON CONFIDENTIALITY

In general, the privacy of all communications between you and a therapist is protected by law, and I can only release information about our work to others outside the therapeutic relationship with your written permission. But there are a few exceptions outlined below:

If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-client privilege law. I cannot provide any information without your written authorization. However, if your records are subpoenaed or if a judge issues a court order for your records, I am legally obligated to comply. In the case of a subpoena, I will contact you so you (and/or your attorneys) can take steps to contest the subpoena. If you do nothing to contest the subpoena after being notified by me, I will obey the subpoena. You agree to furnish me with any request to contest the subpoena and notify me immediately of its outcome.

If I believe that you are a danger to yourself or to other persons, I will contact medical or law enforcement personnel, or I may choose to contact a friend or family member if appropriate.

If you disclose information that leads me to suspect that a minor, elderly, or disabled person is being abused or neglected, I am required by law to notify authorities within 48 hours and I will comply with this requirement.

If you file a lawsuit or a complaint against me for any reason related to your therapy, I am allowed to use confidential information to defend myself.

If a court order, other legal proceedings, statute, or investigation by a municipal, state, or federal agency requires disclosure of your information, I will obey the court order or the law.

If you waive the rights to privilege or give written authorization to disclose information, I will comply with your authorization.

Information contained in communications via computers with limited security/control, such as e-mail and telephone conversations via cell phone is not secure and can compromise your privacy. I will not use these methods of communication for clinical information, but if you choose to do so it can compromise your privacy.

If I learn of previous sexual exploitation by a mental health provider, I am required to report it to the district attorney in the county of the alleged exploitation and the appropriate licensing board of the provider. The client has the right to remain anonymous when the report is filed.

Consent to Treatment:

By initialing here and signing below you hereby authorize me (the above-mentioned provider), who is a solo practitioner, to provide treatment for you and/or your dependents. You authorize the above-mentioned provider to furnish information to your insurance carriers concerning your illness and treatment if you supplied insurance/EAP information to be used for billing purposes

For Parents and Legal guardians:

Payment at the Time of Service:

You understand and agree that payment is due at the time of service for minors or dependents. You understand that medical expenses will NOT be billed; they must be paid at the time of service. You understand and agree that the parent who has financial responsibility for the session will make arrangements for the payment to be made at the time of service regardless of who brings the child to their appointment. You understand and acknowledge that the child may not receive services if payment is not made at the time of service, or further treatment may be withheld.

Custody Evaluations:

You understand that I am not a custody expert and I do NOT provide custody evaluation services. You agree to notify me if you are seeking a custody evaluation and understand that you will be referred to another provider.

Client Signature / Client Agreement to All Terms, Policies, and Information, Including Section on Tele-Health

NOTE: If the client is a minor (under 18 years of age) the parent or guardian must sign on the signature line.

I_____, confirm that I have read and fully understand this document, and by confirming constitutes a legally binding signature.