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THERAPIST-CLIENT SERVICES AGREEMENT

This document contains important information about my professional services and business policies. When you sign this information it represents an agreement between us. You may revoke this Agreement in writing at any time. This document also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protection and patient rights with regard to the use and disclosure of Protected Health Information (PHI). HIPAA requires that I provide you with a Notice of Privacy Practices for using and disclosing PHI for the purposes of treatment, payment, and health care operations. The law requires that I obtain your signature acknowledging that I have provided you with this information.

COUNSELING SERVICES

Psychological counseling is not an exact science; it can have both benefits and risks. In order for it to be most helpful to you it will require a very active effort on your part. There are no guarantees regarding outcome. In our first meetings we will evaluate your therapy needs, and devise a treatment plan. It is expected that you will take an active part in this process, and you will be expected to make your own decisions about whether this is the course you wish to follow.

It may help you to know that I am licensed in the State of Michigan to practice counseling psychology. Licenses are issued by the STATE OF MICHIGAN DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES. I have the following license and certification:

- Licensed Professional Counselor – State of MI – (Board of Counseling #6401000082)

SCHEDULING, PUNCTUALITY AND ATTENDANCE

Counseling sessions are 50-60 minutes in duration unless otherwise arranged. I arrange all appointment times personally. Scheduling ahead allows you the best opportunity for appointment times that are convenient to you. Most therapy sessions are held at weekly intervals. As part of your therapy we will discuss an appropriate schedule of meetings for you.

If you are running late for an appointment, you will still be charged for the full scheduled appointment. If you find it necessary to cancel an appointment, please do this one full business day in advance if possible. Appointments which are not kept without notice are billed at 50% of the standard fee. Insurance companies do not reimburse for appointments that you do not attend. You may notify me of your need to cancel or change an appointment by calling or texting me. If you need to reschedule, please leave your name and phone number for a return call or text. If you think you may be difficult to reach, please leave some suggestions of times when I might reach you.

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PHONE CALLS AND EMAIL

Due to my work schedule I am normally not immediately available by telephone because I do not receive calls while I am with clients. Your call will be answered by my confidential voice mail. If your call is urgent, please state that in your message. On workdays I make every effort to return calls on the same day I receive them. On holidays and weekends I try to return calls promptly on the next work day. If you are unable to reach me immediately, and feel that you can not wait for me to return your call, contact your family physician or go to the nearest emergency room and ask for the psychologist or psychiatrist on call. You may also text or email to contact me for scheduling purposes only. However, please keep in mind that I cannot provide therapeutic conversations over email, due to the limits of confidentiality. Although I check my email regularly, I may not receive, or be able to respond to, your email the same day that you send it. Please keep these matters in mind as you choose your means of contacting me regarding scheduling.

CONFIDENTIALITY

The law protects the privacy of all communications between client and therapist. In most situations information about your treatment only may be released to others if you sign a specific written Authorization Form. There are some situations for which you may provide general permission in advance. Your signature on this Agreement provides consent for those disclosures as follows:

- I may seek a colleague consult to help me in my work with you. I will not disclose your identity or any identifying information during a colleague consult, and I will note this consult in your clinical record (which under HIPAA guidelines is called your Protected Health Information or PHI).
- If you threaten to harm yourself, I may be obligated to seek help hospitalization or support from family members or others whom you have designated.
- I may disclose information to health insurers if you request that I submit claims for you.
- I may disclose information about you in order to collect overdue fees. Currently, I use Paramount Collection Agency.

There are some situations in which I am legally obligated to take actions to protect others from harm. While these situations may require that I reveal information about a client's treatment, I am expected to limit my disclosure to the information necessary to reduce the threat. These required disclosures include:

- If I have reason to suspect the abuse or neglect of a child, an elderly person, a disabled adult, or a person who is under guardianship, the law requires that I file a report with the Family Independence Agency.
- If a client communicates a threat of physical violence against an identified third person, and the client has the apparent intent and ability to carry out that threat, I am required to disclose that threat in order to take protective action. Disclosure in this case may include notifying the potential victim, or the victim's parents in the case of a minor, contacting law enforcement, or seeking hospitalization of the client.

If any of these situations should arise I will make every effort to discuss the matter with you as fully as possible before taking action.

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RECORDS

Under the provisions of HIPAA your Protected Health Information (PHI) is kept in two separate sets of records. They are as follows:

- Your Clinical Record includes information about your reasons for seeking treatment, your diagnosis, your treatment plan, treatment reviews and summaries, progress notes for each visit, your medical and social history, your history of previous mental health treatment, records received from other providers, reports of colleague consultations, your billing records, reports or letters that have been sent to anyone about you including reports to your insurance carrier, your Therapist-Client Services Agreement, any authorizations which you have signed, and a form accounting for any disclosures made about you either with your authorization or as otherwise required by law.
- Counseling Psych Notes may include the contents of our conversations, my analysis of those conversations, informal notes that I make to myself during our meetings, reminders to myself of matters that I wish to pursue with you at a later date, or personal information about you that is not clinical information, for example an announcement about you that appears in the newspaper. These notes may also contain sensitive information that you reveal to me that is not required to be in your Clinical Record. These Counseling Psych Notes are kept separate from your Clinical Record. Psychotherapy Notes are not available to you and normally are not sent to anyone else, including your insurance companies. In the unusual event that I am ordered by law to disclose Counseling Psych Notes, your written, signed authorization would be required.

TREATMENT OF MINORS

Clients under eighteen years of age and their parents should be aware that the law allows parents to examine their child's treatment records. They should also be aware that clients fourteen and over can consent to treatment and control access to information about their treatment, although that treatment can not extend beyond twelve sessions or four months. While privacy is very important, parental involvement is also an important part of successful treatment. For this reason I normally ask minors to agree that we will share general information about meetings attended and progress in treatment, and I ask parents to agree that their child may keep the specific content of meetings private. If I believe that the child is in danger or a danger to someone else, I will notify the parents of my concern, and if it is possible and reasonable to do so, I will discuss this with the minor child prior to the disclosure.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time of service, unless we have agreed otherwise. Payment can be made with check, cash or credit card. My hourly fee is $150 for the initial assessment, and $100 for subsequent sessions. These fees are established based on what insurance companies consider to be "reasonable and customary" for our geographic region. In addition to regular appointments, I charge $100 per hour for other professional services that you may need. Other services may include report writing, assessments and evaluation, consulting with other professionals with your authorization, preparation of records and treatment summaries, my participation in legal proceedings that pertain to you, and time spent performing any other service you may request of me. *Prior to providing these additional services, I will discuss the cost for them with you.*

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If your account has not been paid for more than 90 days and no arrangement for payment has been agreed upon, late payment fees of 1.5% per month will be charged, and I have the option of using legal means to secure payment. This may involve hiring a collection agency (in which case, a 30% delinquency fee will be added to your balance) or going through small claims court (in which case, legal costs will be included in the claim). These situations are rare; in the case they may be needed, only the minimum information necessary (client name, nature of services provided, dates of service, and amount due) will be disclosed. ***Please do not let this happen; I would much rather communicate & find some solution to overdue accounts.***

INSURANCE

If you have a health insurance policy, it may provide coverage for mental health treatment. Although I offer billing services, it is your responsibility to know the amount of your mental health co pay and to pay that amount at the time of the service. Your health insurance policy is an agreement between you and your insurance company. Similarly the contract for my services is with you and not with your insurance company. You should contact your insurance carrier regarding your coverage and potential limits of your coverage.

You should also be aware that your contract with your health insurance company requires that I provide information relevant to the services I provide to you. This information routinely includes a diagnosis, the dates of service, and the type of service which I have provided to you. In rare circumstances they may request further information from your Clinical Record or a disclosure of the full record. I will make every effort to release only the minimum information about you that is necessary for submitting and following up a claim. You have a right to know what information I release to the insurance company, and by signing this Agreement you give me permission to provide information to your carrier.

SIGNATURE

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE RECEIVED THE HIPAA NOTICE, THAT YOU GIVE YOUR PERMISSION TO HAVE INSURANCE CLAIMS SUBMITTED FOR SERVICES RENDERED TO YOU FOR THE PURPOSE OF SEEKING REIMBURSEMENT, AND THAT YOU HAVE READ THE THERAPIST-CLIENT SERVICES AGREEMENT AND CONSENT TO ITS TERMS (INCLUDING RESPONSIBILITY FOR PAYMENT OF SERVICES).

_____ _____

Signature of Client/Parent Date

_____ _____

Provider Signature Date

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