CONSENT TO TREATMENT AGREEMENT

This document (the Agreement) contains important information about our professional services and business policies.

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections and new patient rights regarding the use and disclosure of Protected Health Information (PHI) used for treatment, payment, and health care operations. HIPPA mandates providing you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice (following this Agreement) explains HIPPA in greater detail and its application to your personal health information.

This document represents an agreement between you and your therapist. You may revoke this Agreement in writing at any time.

Note this Agreement uses the terms psychotherapist and therapist interchangeably and the term client and patient also are used interchangeably.

THERAPY SERVICES

Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Therapy requires your active involvement, honesty, and openness to change your thoughts, feelings and/or behavior. During therapy, remembering or talking about unpleasant events, feelings, or thoughts can at times result in your experiencing uncomfortable feelings such as anger, sadness, worry, fear, etc. Attempting to resolve issues that brought you to therapy in the first place may result in changes that were not originally intended. Therapy may result in decisions about changing a variety of things in your life. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Sometimes change is easy and swift, but more often it is slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

If you have questions about the procedures employed by your therapist, discuss these when they arise. If your doubts persist, you have the option of speaking with the Director or another staff member, or setting up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

Therapy sessions are typically 45-60 minutes in length at a time we agree on, although some sessions may be longer. ***Once an appointment is scheduled, you will be expected to pay the therapist's full fee unless you provide 24 hours advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control).***

*****If there is more than one last minute cancelation, we will ask that you provide a credit card to be kept on file. There will be a $60 fee charged to that credit card for last minute cancelations. By signing this agreement you are consenting and agreeing to these terms***

FEES, BILLING AND PAYMENTS
You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement.

You also may be charged for other professional services you may need. No fee for non-therapy services will ever be charged without your knowledge and approval ahead of time. Other services include report writing**($50/hour)** telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request. ***If you become involved in legal proceedings that require participation by your therapist, you will be expected to pay for all of the therapist's professional time ($200/hour), including preparation and transportation costs(mileage at state reimbursement rate .56cents/mile), even if the therapist is called to testify by another party.***

Clients are expected to pay in full for missed sessions or sessions cancelled less than 24 hours prior.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we may use legal means to secure payment. By signing this agreement, you understand that you are responsible for reasonable attorney and legal fees for accounts that go into collections.

INSURANCE REIMBURSEMENT
A health insurance policy may provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. Our staff will make every effort to receive payments for services from your insurance company. ***However, if, for any reason whatsoever your insurance does not pay, you are responsible for paying the entire fee.***
You should be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. In these situations, your therapist is required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. By signing this Agreement, you agree that your therapist can provide requested information to your carrier.
You always have the right to pay for services yourself to avoid the problems described above.

LIMITS ON CONFIDENTIALITY
The law protects the privacy of all communications between a client and a therapist. In most situations, information about your treatment can only be released to others if you sign a written Authorization form. Your signature on this Agreement provides consent for the following:

- On occasion we may mail out or email you information regarding upcoming programs.
- Disclosures required by health insurers or to collect overdue fees.
- If a patient threatens to harm himself/herself, we may be obligated to seek hospitalization for

him/her, or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

• 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. We cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.

• If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

• If a patient files a complaint or lawsuit against a therapist, the therapist may disclose relevant information regarding that patient in order to defend themselves.

• If we are being compensated for providing treatment to you as a result of your having filed a worker's compensation claim, we must, upon appropriate request, provide information necessary for utilization review purposes . There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a client's treatment. These situations are very rare.

• If we have reasonable cause to suspect child abuse or neglect, the law requires that we file a report with the Family Independence Agency. Once a report is filed, we may be required to provide additional information.

• If we have reasonable cause to suspect the "criminal abuse" of an adult patient, we must report it to the police. Once a report is filed, we may be required to provide additional information.

• If a client communicates a threat of physical violence against a reasonably identifiable third person and the client has the apparent intent and ability to carry out that threat in the foreseeable future, we may have to disclose information in order to take protective action such as notifying the potential victim (or, her/his legal guardian and the county Department of Social Services), contacting the police, and/or seeking hospitalization for the client.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and will limit our disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and psychotherapists are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record that may include your reasons for seeking therapy, a description of how your problem impacts on your life, your diagnosis, treatment goals, progress notes, medical and social history, treatment history, any past treatment records received from other providers, billing records, and any reports sent to anyone, including your insurance carrier.

You may examine and/or receive a copy of your Clinical Record, if you request it in writing, except in unusual circumstances where disclosure could or would physically endanger you and/or others; or makes reference to another person and your therapist believes that access is reasonably likely to cause substantial harm to that other person; or where information has been supplied confidentially by others. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. Therefore, we recommend that you initially review them in your therapist's presence, or have them forwarded to another mental health professional so you can discuss the contents.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights, which are also listed in the Notice of Privacy Practices, include requesting an amendment to your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice of Privacy Policy. Your therapist will be happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. They should also be aware that patients over 14 can consent to (and control access to information about) their own treatment, although that treatment cannot extend beyond 12 sessions or 4 months. While privacy in therapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment. Therefore, it is usually our policy to request an agreement from any client between 14 and 18 and his/her parents allowing the therapist to share general information with parents about the progress of treatment and the child's attendance at scheduled sessions.

CLIENT CONSENT TO TREATMENT and ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read this Consent to Treatment Agreement carefully, I understand the information that was presented here and by signing this form I accept and fully agree to be treated according to the above conditions and client/therapist responsibilities.

IN ADDITION, I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

_____	_____	_____
Client name (print)	Signature	Date

_____	_____	_____
Client name (print)	Signature	Date

_____	_____	_____
Therapist name (print)	Signature	Date

Please Note: In emergencies, if you are unable to reach your therapist and feel that you can't wait for a return call, contact your family physician or the nearest emergency room. If your therapist will be unavailable for an extended time, she will provide you with the name of a colleague to contact, if necessary.