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Client –Therapist Agreement Form

Welcome to *Sanctuary Counseling & Supervision Services, LLC*. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights about the use and disclosure of your Protected Health Information (PHI) used to the purpose of treatment, payment and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, **it is very important that you read them carefully**. Please initial each section, acknowledging that you have read and understand the policies. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me, unless I have acted already relying on it, or if there are obligations imposed on me by your health insurance to process and/or substantiate claims made under your policy, or if you have not satisfied any financial obligations you have incurred.

THERAPY SERVICES X _____

Counseling Therapy is not easily described in general statements. It varies depending on the personalities of the counselor and client, and the problems you are experiencing. There are many different methods I may use to deal with the problems you hope to address. Therapy is like a medical doctor visit in which it calls for a very active effort on your part. For the therapy to be most successful, you will have to work on things we talk about during our sessions as well as on your own between sessions. Therapy can have benefits and risks, and there are no guarantees of what you will experience. Therapy has also shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. On the other hand, since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like anxiety, sadness, guilt, anger, frustration, loneliness and helplessness. This is "normal" part of the process.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you my impressions of what our work will include and a treatment plan to follow, if you decided to continue with therapy.

You should evaluate this information along with your own opinions of whether you feel comfortable working with me.

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Therapy involves a large commitment of time, money and energy, so you should be very careful about the therapist you ultimately select. If you have questions about my procedures, we should discuss them whenever they arise. If doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

SESSIONS X _____

I normally conduct an evaluation that will last from two to four sessions. During this time, we can both decide if I am the best person to provide the services you need to meet your treatment goals. I will usually schedule one forty-five (45) to sixty (60) minute session per week at a time we agree on, although some sessions may be longer or more frequent.

Once an appointment is scheduled, unless previously discussed, there is a $100 flat charge for a cancellation that is given with less than 24 hours' notice. This holds true for insurance users, those paying out of pocket, group members, and reduced fee patients. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. The full session rate will be charged to a credit card on file if no communication is made prior to the appointment. This is necessary because a time commitment is made to you and is held exclusively for you. Likewise, if I am unable to keep an appointment with you within the 24-hour cancellation period, you will not be charged for that session, and I will reschedule you for my earliest opening. Please note that there will be no reminder phone calls for your scheduled appointments, though there will be text & email reminders. Each person is responsible for holding their scheduled appointment. ***If texting a cancelation please make sure there is confirmation back from me within a 3-hour time window. If you don't receive acknowledgment of your need to cancel, please call versus relying on other forms of communication.***

PROFESSIONAL FEES X __

My therapy fees are as follows:

Individual Therapy		Couple or Family Therapy	
45-minute session	$100	60-minute session	$150
60-minute session	$130	90-minute session	$200
90-minute session	$170	120-minute session	$250
120-minute session	$200	3-hour intensive (2 1.5-hour sessions over a short time span)	$500

*** Please note:** Insurance companies set their own pay rates & copays. Marital therapy is often not covered by insurance, nor is it often wise for that to be the case**.** I maintain 2 low-fee slots, reduce fees for students, and am considerate with temporary hardship. Session time includes scheduling & payment. Cash, check, debit, credit & PayPal accepted. HSA and FSA cards are accepted if the card includes a symbol for a primary credit card agency.

In addition to weekly sessions**, I charge for other professional services you may need**. These typically include telephone conversations lasting longer than five minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and time spent performing any other services you may request of me.

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If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, including preparation and transportation costs, even if I am called to testify by another party.

Because of the difficulty of legal involvement, I charge a separate fee per hour for preparation and attendance at any legal proceeding. Let me know if you would like a copy of that policy.

TELEPHONE CONTACT X_____

Due to my work schedule, I am often not immediately available by telephone. I do not answer the telephone when I am with a client. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the same day you place it. This may not always include weekends or holidays.

If you have an emergency that cannot reasonably wait until the end of the business day, you are urged to call 911 or contact the nearest emergency room and ask for the psychiatrist on call.

LIMITS ON CONFIDENTIALITY X_____

The law protects the privacy of all communications between a client and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. These are situations that require that you provide written, advance consent. Your signature on this Agreement provides consent for those activities as follows:

- Email and/or text reminders of upcoming events or appointments.

- I may occasionally find it helpful to consult other medical and mental health professionals about a case.

  During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. Unless you wish that I do so, I will not tell you about these consultations unless I feel that it is important to our work together. I will make note of these consultations in your clinical record.

- At times I may employ administrative staff to help with scheduling and quality assurance practices. I may need to share protected information, such as your name and telephone number, with these individuals for purely administrative purposes. Each person employed will sign a confidentiality agreement.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in the Agreement.

- If a client threatens to harm him/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can provide protection. There are some situations where I am 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 my professional services, such information is protected by the therapist-client privilege law. I 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 me to disclose information.

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- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

- If a client files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all psychological reports and bills.

  There are some situations in which I am legally obligated to act, and which I believe are necessary, to attempt to protect others from harm. I may have to reveal some information about a client's treatment. In my practice, such situations are very unusual.

- If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Family and Children's Services. Once such a report is filed, I may be required to provide additional information.

- If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report this to an agency designated by the Department of Human Resources.

  Once such a report is filed, I may be required to provide additional information.

- If I determine that a client presents a danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and will limit my 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. In situations where specific advice is required, formal legal consultation may be necessary.

PROFESSIONAL RECORDS X_____

You should be aware that, pursuant to HIPAA, I keep Protected Health Information (PHI) about you in two sets of professional records. One set constitutes your clinical record. It includes information about your reasons for seeking therapy, a description of the ways in which your problems impact your life, your diagnosis, the goals we have set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Exceptions to this are unusual circumstances that involve danger to yourself or others, or circumstances that refer to another person (unless such other person is a health care provider), and I believe that access is reasonably likely to cause substantial harm to such other person, or if information is supplied to me confidentially by others.

You or your legal representative may examine and/or receive a copy of your clinical record if you request it in writing.

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Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right or review (except for information provided to me confidentially by others), which I will discuss with you upon request.

In addition, I also keep a set of psychotherapy notes. These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of psychotherapy notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact your therapy.

They may also contain particularly sensitive information that you may reveal to me that is not required to be included in your clinical record, and information supplied to me confidentially by others. Your psychotherapy notes are kept separate from your clinical record. Your psychotherapy notes are not available to you, and cannot be sent to anyone else, including insurance companies, without your written, signed authorization. Insurance companies cannot require your authorization as a condition of coverage, and they cannot penalize you in any way for your refusal to provide them.

PATIENT RIGHTS X _____

HIPAA provides you with several new or expanded rights regarding your clinical record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of protected health information (PHI)that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice Form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

BILLING AND PAYMENTS X_____

You will be expected to pay for each session at the time of service. If payments are not made at time of service, no further appointments will be scheduled until payment is made. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon, I may use legal means to secure payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his or her name, the nature of the services provided, and the amount due. If such legal action becomes necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT X_____

I currently file with Blue Cross/Blue Shield of Georgia, Cigna, & CHAMPVA If you have a health insurance policy, it will usually provide some coverage for mental health treatment. If you have another insurance company that you use, you must file your own insurance claims. I do not employ anyone to file insurance claims. I will provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, **you, not your insurance company, are**

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responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should also be aware that your contact with your health insurance company requires that I provide them the information relevant to the services I provide to you. A clinical diagnosis will be required for reimbursement.

Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I 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 your insurance company's files and will be stored in a computer.

Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is their hands. In some cases, they may share the information with a national medical information databank.

I will provide you with a copy of any report I submit, if you request it in writing. By signing this Agreement, you agree that I can provide requested information to your carrier.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Name (Print) _____

Signature_____

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