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CLIENT SERVICE AGREEMENT

Welcome to my practice! The following is information regarding the policies and procedures for Allison L. Sharpe, LCMHC, PLLC. Although I share office space with other practitioners I am my own legal entity, Allison L. Sharpe, LCMHC, PLLC and I am an independent practitioner who practices alone. I have no legal or business connections to any other practitioner in this office or elsewhere. This document contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for 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. 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. The Client Services Agreement includes useful information regarding business practices, including billing, clinical, privacy, and office policies**. I encourage you to read the following information carefully and to discuss each and every item with me if and when you have any questions.**

CODE OF ETHICS

As a Licensed Independent Clinical Mental Health Counselor I am governed by the Code of Ethics of the National Board for Certified Counselors. A copy of it is available upon request.

SCOPE OF PRACTICE

The scope of services that I provide includes outpatient individual and family treatment to adults and adolescents. Information regarding the following is available at any time upon request: Code of Ethics; nature and scope of my practice; my professional education, and qualifications and experience and grievance policy.

MENTAL HEALTH BILL OF RIGHTS

Pursuant to the New Hampshire Mental Health Bill of Rights, clients have certain rights. A copy of the Mental Health Bill of Rights is included with this form and posted in the waiting area. Please review the bill of rights carefully and let me know if you have any questions.

DIAGNOSIS AND RECOMMENDED TREATMENT

As part of your treatment, I will discuss your diagnosis and my proposed treatment plan, including my estimate of the length of therapy. You should also note that there are both likely benefits and risks to psychotherapy. Since therapy often involves discussing unpleasant aspects of your life, you may

experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

You should also be aware that there are alternative types of services to those being offered by me. You may prefer to obtain counseling from someone other than me. You also have the choice not to obtain any counseling services. There are also risks and benefits associated with alternatives and with not pursuing any counseling. To the extent that you are interested in alternatives, you should discuss this with me.

CONFIDENTIALITY/ REPORTING REQUIREMENTS

Under New Hampshire law, communications between a client and a licensed psychotherapist are privileged (confidential) and may not be disclosed without specific written authorization of the client, except under specific, limited circumstances. Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled. In addition, client records can be released in accordance with a specific court order or in certain circumstances by order of New Hampshire regulatory authorities.

As part of maintaining a valid license, I am required to regularly discuss cases with colleagues. I also obtain formal supervision on certain cases when I believe it is necessary. In these situations, I do not disclose the identity of my client. My colleagues are, of course, legally bound to confidentiality as well. By signing this document, you are acknowledging that you understand that I may discuss your case in consultation and/or supervision and that you do not object to my doing so.

MINORS

FOR MATURE MINORS

Because you are a minor (under the age of 18), I cannot treat you without parental consent. Parental control over your treatment includes their right to access and release your medical records.

In very limited circumstances, a minor may prevent parental access to treatment records through a court hearing. In the event you object to either parent/legal guardian having access to your treatment records, I encourage you to raise this issue with your other parent/legal guardian or with a guardian ad-litem, if one has been appointed.

MAINTAINING PROFESSIONAL BOUNDARIES AND DUAL RELATIONSHIPS:

Therapists are obligated to maintain appropriate professional boundaries with current and past clients. For example, New Hampshire law states that “sexual relations with a client or former client shall be considered misconduct…and shall be subject to disciplinary action…. Mental health counselors make every effort to avoid dual/multiple relationships with clients that could impair professional judgment or increase the risk of harm. Examples of such relationships may include, but are not limited to: familial, social, financial, business, or close personal relationships with the clients. Reports of any such misconduct should be filed with the Board of Mental Health Practice, 117 Pleasant St, Dolloff Building, ground floor, Concord NH 03301, (603) 271-6762.

Please note that in order to respect your privacy, if I see you in public I will take the cue from you and only acknowledge you if you initiate contact.

SOCIAL MEDIA POLICY

Please read the following to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet. If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

FRIENDING

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Instagram, 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. (from Keely Kolmes, Psy.D)

CONFLICTS OF INTEREST

New Hampshire is a small state. From time to time, actual or potential conflicts of interest may arise. In the event that I become aware of a conflict of interest in providing treatment to you, I may be required to refer you to another therapist. Regardless of the existence of a conflict of interest, you can be assured that any information will remain confidential.

If you are seeing me due to a court order requiring you to seek treatment, it is my policy that we not proceed with treatment until I have received a copy of the court order and have had an opportunity to review it. Because you have been ordered by the court to obtain treatment, there are limits on confidentiality in addition to the ones described in the above paragraph entitled Confidentiality. For example, I may be obligated to file a report with the court that ordered you to seek treatment or with someone else.

PROFESSIONAL RECORDS

I maintain a file for each client or set of clients. This includes intake, diagnosis, treatment plan, billing, consent to treatment, treatment notes, discharge summary and any other written or electronic information I received from or about the client. Treatment notes include the date of each session and a brief summary of key facts and issues discussed as well as treatment recommendations. The client is entitled to a copy of the records, for a fee that covers copying and administrative costs. You can expect to receive your copy within 30 days. If you wish to see a copy of your records, I recommend that you review them with me so that we can discuss the contents. You should also be aware that I am required to have a plan in place for how my clinical records will be managed in the event of my disability or death. I have made such arrangements in order to ensure that you will still have access to your records, and in order to protect the confidentiality of your records. In the state of New Hampshire, I am required by law to keep your records for 7 years.

ELECTRONIC COMMUNICATIONS

Some vendors require that I send billing and other information electronically (e.g., by facsimile or e-mail). I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you communicate via email for issues regarding scheduling or cancellations, I will do so. I encourage you to discuss this issue thoroughly with me so that you are aware of the boundaries and limits of confidentiality.

While I 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.

I am ethically and legally obligated to maintain records of each time we meet, talk on the phone, or correspond via electronic communication such as email or text messaging. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. A judge can subpoena my records for a variety of reasons, and if this happens, I must comply.

LIMITS OF AVAILABILITY

My office hours are by appointment only. I am in this office for a limited amount of hours during the week and I am not always available by phone. If a clinical emergency/crisis should arise, you should call the office and leave a message stating the nature of your emergency. I will make every effort to return your call within 30 minutes. If you are having a life threatening emergency and cannot wait for a call back, you will need to dial 911 or access your nearest hospital/medical provider for evaluation and possible further treatment. If I am away from the office on vacation, a different therapist will be available to you for emergency situations.

For non-emergency phone contact in between sessions, please leave a message on my office voicemail, but please understand that due to my schedule I may not be able to return your call until the next business day that I am in the office. If your message does not require a return phone call, please note that in your message.

In addition, although I will make every effort to give you a set appointment time, due to my schedule this may not always be possible.

RECOMMENDED TREATMENT

After your initial assessment, and throughout your relationship with me, I will discuss recommendations for treatment with you. I strongly encourage you to ask any questions you may have about the recommended treatment.

TERMINATION:

You have the right to terminate therapy and communication at any time. If you choose to do so, upon your request and if appropriate and possible, I will provide you with names of other qualified professionals whose services you might prefer.

If you choose to terminate, I encourage you to talk about your reasons and readiness and the alternate supports you have, even if this may be a difficult conversation. It is not uncommon for life difficulties to repeat themselves in the psychotherapeutic relationship and can be fertile material for self-understanding and growth. Should you choose to terminate, I encourage you to have at least one final session to discuss ending any chapter of therapy, even if you intend to return in the future.

FINANCIAL INFORMATION

Please read the next three (3) sections very carefully so that you are aware of your financial responsibilities

OFFICE POLICIES AND COST OF SERVICES

My fee for individual or family sessions is $125.00 per 45-50-minute, and $150.00 for initial intake sessions. I do accept some health insurances for payment of sessions and will make every effort to bill accordingly as a courtesy to you. Please be aware that each insurance plan that I am contracted with reimburses at a different rate, which I have agreed to accept. If I am contracted with your insurance company, you will pay only for the deductible and co-pays. However, you are responsible for knowing what your insurance benefits are as you are ultimately financially responsible for the cost of services should your insurance company deny a claim. Should your sessions not be covered by your health insurance plan, you will be responsible for payment at the above rate.

In addition, because I need to focus my time on providing the best treatment possible to my clients and because I have no office staff to assist me, I am not able to investigate claims that have been denied by your insurance company, even though you believe that they should be covered. Any claim that is denied will be resubmitted one additional time. I will ask for your help if I am not paid after 2 submissions. You will be responsible for payment of all denied claims in full before additional sessions are scheduled. You may also be asked to pay out of pocket for any future services.

If you are paying out of pocket or have a co-payment amount, payment is due at the time of service. I accept cash, checks, credit, debit and HSA cards. All checks should be made out to Allison Sharpe, LCMHC, PLLC and should be written out prior to your appointment to avoid using clinical time for this purpose. Please note there will be a $25.00 charge for all returned checks.

CANCELLATION POLICY

Appointment times are reserved for you. If you are unable to keep an appointment**, please call 48 business hours in advance to cancel**. Unless the driving conditions are dangerous, or you are ill, all sessions that are missed or not cancelled within 48 hours will be charged to you at a rate of $75.00/missed session as I cannot bill insurances for those sessions. For Monday sessions, you must call the office by the Friday before in order to cancel your appointment so that I have time to fill your slot. When appointments are missed or not cancelled within the requested time, your credit card on file will be billed. Payment is due prior to your next sessions.

CHARGES FOR ADDITIONAL SERVICES

In addition to face to face appointments, it is my practice to charge $125.00/hour on a prorated basis (I will break down the hourly cost into 10 minute intervals) for other professional services that you may require such as report writing, telephone conversations that last longer than 10 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. Insurance companies will not pay for these services. Insurance companies will not reimburse for these services.

Please be advised, my role is to provide therapy services. I will not assess fitness for custody, serve as an advocate on other issues or act as an expert witness in any legal matters. However, you should be aware that if you should become involved in a legal matter and I am subpoenaed to court, even by another

party, you will be charged a fee of $125.00 per hour for any time spent in court (even when not testifying), travel time and preparation time. You will be required to provide me with a prior retainer for my services. Lastly, should I be subpoenaed to court and be required to seek legal advice or assistance, you will also be responsible for those legal fees.

MANAGED CARE

Most managed care companies limit the number of outpatient counseling sessions which will be fully, or partially, reimbursed. It is your responsibility to know and keep track of your benefits. You are STRONGLY encouraged to communicate directly with your managed care company about such limitations before starting treatment. Also, please be aware that in order to receive payment from your managed care company, I am required to provide them with confidential information regarding your treatment, including a mental health diagnosis. I am unable to guarantee the confidentiality of this information once it is provided to the managed care company. Any concerns about the confidentiality of your managed care records should be directed to the managed care company. You should also be aware that there are potential risks associated with any written diagnosis being submitted to your managed care company. The only way to prevent this information from being shared with your managed care company is for you to pay for your sessions privately. Please discuss with me immediately if you would like to choose the private pay option.

ACKNOWLEDGEMENT AND ACCEPTANCE

I understand that I am required to pay at time of service and that I will be responsible for all co-pays and deductibles at the time of service. I also understand that I will be responsible for any missed sessions or sessions not cancelled within 48 business hours (by the Thursday before, for Monday appointments) at the rate of $75.00 per missed session, even if my sessions are usually paid for by another source.

I also understand that Allison L. Sharpe LCMHC, PLLC will submit claims to my insurance company and that any claims that are denied or remain unpaid will be my financial responsibility. I also understand that no further sessions will be scheduled until these claims are paid in full. I understand that if my insurance company denies claims, I may be asked to pay out of pocket for all future sessions.

I authorize Allison L. Sharpe LCMHC, PLLC to bill any outstanding patient balance each month to the credit card indicated in the Financial Responsibility Form attached.

Lastly, I understand that I am financially responsible for all ancillary services, including report writing, telephone calls, discharge summaries, etc., even if requested by a court. Those services cannot be paid by my insurance company and must be paid out of pocket by me.

My signature below indicates that I have read and understand this document and agree to abide by its terms.

Date: _____ _____

Client/ Guardian Signature