Richard Shannon Therapy
Rich Shannon, MA, NCC, LMFT, LCADC
775 560 5326
Nevada Licensed Marriage and Family Therapist #01230
Nevada Licensed Clinical Alcohol and Drug Counselor #00371-LC

AGREEMENT FOR TREATMENT AND INFORMED CONSENT

INTRODUCTION: This 6 page Agreement (hereafter referred to as Agreement) is intended to provide you (hereafter referred to as Client(s) with important information regarding the practices, policies and procedures of Rich Shannon, Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Alcohol and Drug Counselor (LCADC) (hereafter referred to as Therapist), and to clarify the terms of the professional therapeutic relationship between Client(s) and Therapist. If Client(s) has any questions or concerns regarding the contents of this Agreement please discuss this with Therapist prior to signing it. Client(s) understands that their signature on page 4 of Agreement indicates that they understand and agree to the information, policies and procedures contained in Agreement.

CONFIDENTIALITY: Client(s) understands that their signature on page 4 of Agreement indicates that they understand that what he/she says in session and over the telephone is confidential information and will not be released without his/her written consent. Client(s) understand that when therapy involves more than one person the information belongs to all Client(s) involved and will not be released unless all Client(s) agree. Client(s) understands that Therapist protects this information to the best of Therapist's ability and within what is considered reasonable. Client(s) understands that confidentiality can not be absolutely guaranteed. Client(s) understands that at a minimum the following exceptions to confidentiality exist:

1. Therapist has reason to suspect child/elder abuse/neglect.
2. Therapist has reason to suspect client is a danger to himself/herself or others.
3. When required by a court of law.

RECORDS AND RECORD KEEPING: Client(s) understands that their signature on page 4 of Agreement indicates that they understand any notes or records that Therapist creates regarding Client's contact with Therapist, Client's treatment, Client's diagnosis, Client's billing or other information recorded by Therapist are Therapist's property. Client(s) understands that under normal conditions these records will be destroyed seven years after his/her last appointment.

THERAPUETIC PROCESS: Client(s) understands that their signature on page 4 of Agreement indicates that they understand the therapy process involves the potential for both risk and benefit. Client(s) understands that during the therapy process he/she may discuss, recall and/or process difficult thoughts, memories and/or behaviors. Client(s) understands that the therapy process may create discomfort in order to achieve the goals he/she desires.

FEES: Client(s) understands that their signature on page 4 of Agreement indicates that they understand that the Therapist's fee for services is $200 for the initial visit and $165 per 50 minute session thereafter. Client(s) understand that payment is required at the time of services.

INSURANCE BILLING: Client(s) understands that if prior arrangements are made that the Therapist bills insurance companies as a convenience to the Client(s) and that the Client(s) is responsible for all Therapist fees not paid by insurance providers. Client(s) understands that Therapist is not responsible for determining copays, deductibles, coverage limits etc. and that the Client(s) is responsible for being informed about the Client's insurance coverage and benefits.

Client(s) understands that their signature on page 4 of Agreement indicates that they understand and authorize the Therapist to provide information to insurance providers including diagnosis, dates of service, treatment plans and other information requested by the insurance provider.

Client(s) understands that their signature on page 4 of Agreement authorizes Therapist to receive payment from insurance providers.

Client(s) understands that their signature on page 4 of Agreement indicates that they have been offered and reviewed the Privacy Practices and HIPAA information contained on pages 5 and 6 of Agreement.

Client(s) understands that their signature on page 4 of Agreement indicates that they understand and authorize the Therapist to charge the credit card on file for all charges not paid by their insurance provider within 30 days of Therapists mailing of bill for services. Client's initials indicate that the Client(s) accepts ultimate responsibility for paying Therapist's fees.
Initials_____

ADDITIONAL SERVICES: Client(s) understands that their signature on page 4 of Agreement indicates that they understand that Therapist does not normally appear in court on Client's behalf. Client(s) further understands that Therapist does not normally produce letters, reports or other requests. Client(s) understands that if Therapist is subpoenaed and court ordered to appear on Client's behalf that Client(s) will pay the above rate as an hourly fee for travel, preparation and time spent in court. Client(s) understands that if Therapist does produce letters, reports or other requests that the above rate will be charged as an hourly fee for time spent in this process.

CANCELATIONS: Client(s) understands that their signature on page 4 of Agreement indicates that they understand that cancelations must be made 24 hours in advance of scheduled appointments by phoning Therapist at 775 560 5326. Client(s) understands that failure to provide Therapist with cancelation notice may result in termination of services.

Client(s) understands that their signature on page 4 of agreement indicates that they understand and agree that failure to provide a 24 hour cancelation notice will result in a $100 charge to the credit card on file.
Initials_____

CREDIT CARD INFORMATION

Name on card_____

Card Type_____ Card Number_____

Expiration Date_____ Security Code_____ Billing Zip_____

APPOINTMENT REMINDERS: Client(s) understands that their signature on page 4 of Agreement indicates that Client(s) understand that by initialing below Client agrees to accept appointment reminders as indicated:

Initials_____ (Circle preference) By email, text message, voice message, no reminders at:

_____

EMERGENCIES AND THERAPIST AVAILABILITY: Client(s) understands that their signature on page 4 of Agreement indicates that Client(s) understands that Therapist is only available to Client(s) during Client's scheduled appointment times and that Therapist is NOT available on a 24 hour, on call or emergency basis.

Client(s) understands that their signature on page 4 of Agreement indicates that Client(s) understands that Therapist can be reached at 775 560 5326, that this is a cell phone and that Therapist will within reason attempt to protect Client's confidentiality regarding any messages Client(s) leaves.

Client(s) understands that their signature on page 4 indicates that they understand and agree that Therapist will attempt to return any calls within 48 business hours and that Client(s) understands that 775 560 5326 IS NOT an emergency number. Client(s) further understands that this phone is for scheduling and appointment confirmation only and that therapy does not occur outside of scheduled appointments.

Client(s) Contact Information:

Name(s)_____

Address_____

_____

Primary phone_____ Insured's date of birth_____

Client(s) understands that their signature on page 4 of Agreement indicates that they understand and agree that it is acceptable to leave information on the above numbers that may indicate or reveal the therapeutic relationship Client(s) has/have with Therapist.

Emergency contact_____

Client(s) understands that their signature on page 4 of Agreement indicates that they understand and agree that if Therapist has a need to contact the above noted individual(s) in the case of an emergency during or related to therapy involving Client(s), Client(s) grants Therapist permission to release information as Therapist deems appropriate to the situation.

List current prescription medications and/or existing health issues_____

List any prior therapy experiences_____

ACKNOWLEDGEMENT BY CLIENT: Client(s) understands that their signature on page 4 of Agreement indicates that they understand the office practices of Therapist as described in Agreement, the Therapist standing as a LMFT/LCADC and Client(s) agrees to abide by the terms of the Agreement and to participate in therapy.

Client(s) understands that their signature on page 4 of Agreement indicates that they understand and agree that all questions related to Agreement were answered to his/her satisfaction.

Client(s) understands that their signature on page 4 of Agreement indicates that they understand and agree to hold Therapist (Rich Shannon, LMFT/LCADC) free and harmless from any claims, demands or suits for damages whatsoever, save negligence that may result from therapy services.

Printed Client Name(s)_____

_____

Client Signature(s)_____

_____

Date_____

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") describes the legal obligations of Richard Shannon Therapy (I, me) and your legal rights regarding your protected health information held under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. I am required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

If you have any questions about this Notice or about my privacy practices, please discuss them with me.

This Notice is effective the date you sign the consent for treatment.

I am required by law to maintain the privacy of your protected health information; provide you with certain rights with respect to your protected health information; provide you with a copy of this Notice of my legal duties and privacy practices with respect to your protected health information and follow the terms of the Notice that is currently in effect.

I reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that I maintain, as allowed or required by law. If I make any material change to this Notice, I will provide you with a copy of my revised Notice of Privacy Practices.

I will primarily use your protected health information to facilitate payment by your insurance provider or another third party payor.

I may disclose your protected health information under the following circumstances or conditions:

when required to do so by federal, state or local law.

to prevent a serious threat to your health and safety, or the health and safety of another person(s).

in response to a subpoena and court order.

to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining my compliance with the HIPAA privacy rule.

When you request, I am required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits.

I am also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

To inspect and copy your protected health information, you must submit your request in writing. If you request a copy of the information, I will charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

You have the right to be notified in the event that I discover a breach of unsecured protected health information.

You have the right to a paper copy of this notice.

If you believe that your privacy rights have been violated, you may file a complaint with me or with the Office for Civil Rights of the United States Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with me.