CLIENT CONSENT FOR TREATMENT

Please READ and SIGN

CONFIDENTIALITY

All sessions are completely confidential in accordance with law and recognized professional standards. You understand that there are certain circumstances when the confidential nature of our counseling sessions may not be honored. Specifically these are: 1) When you disclose that you are the perpetrator or victim of neglect or abuse; 2) When you make a threat toward your own or someone else's physical health and/or safety (this may include sexual behavior or drug use that may expose you or others to the AIDS virus); 3) You are under age 18 and a parent or guardian is involved; 4) Local, State or Federal law and/or the Court requires disclosure; 5) You give me your written authorization. If you provide me your written authorization to communicate with others outside your presence, you may revoke your written permission by writing and requesting such. If you revoke such permission, you understand that I cannot take back any uses or disclosures I have already made with your permission. All information in your file is considered confidential information. Your file is my property and any related employee and/or contractor will have access to your file. Additionally, you will not have automatic access your file. If you desire any information from your file you will need to make your request in writing and it will be provided to you in a reasonable timeframe. Specifically, copies of files are rarely made available at the time the request is made. If you are involved in a Court proceeding, my file will not be made available to anyone other than you unless subpoenaed. My file may be vulnerable to being subpoenaed by other interested parties. If you believe the health information I have about you is incomplete or incorrect, you may request that I amend the information. You may obtain, by written request, a list of all disclosures of your health information. You have the right to request in writing that I limit the disclosure of your health information; however I may or may not be able to comply with your request depending on the laws and regulations governing the specific situation. You may request in writing that I limit my communications with you about health matters; however I am not required to comply with your request depending on the laws and regulations governing the specific situation. If you believe your privacy rights have been violated, you may file a complaint with me, or the Secretary of the US Department of Health and Human Services. When submitting your receipt to insurance companies, you are aware that insurance companies are entitled to diagnosis, date, and type of service. If you need to communicate with me regarding scheduling and/or treatment, you agree to call or email me at your convenience. I make myself available to you via phone calls and emails, however I will not be able to communicate with you via text messages. By signing this agreement, you are aware that communication via email on a Gmail, GoDaddy or any other server, is not completely confidential and your protected health information is at risk.

INFORMED CONSENT

Therapy is an interactive process between client and therapist, and the results of therapy depend on your cooperation. It is meant to promote change and understanding. Sometimes this process can be emotionally painful, and at other times, very fulfilling. You will be expected to contribute to all decisions regarding therapeutic interventions (including out of session assignments), treatment planning, and periodic treatment plan reviews. You have the right to refuse or alter any service and intervention. While I will use best my efforts to assist you, the nature of psychological services is that there can be no assurances of results and no promises can be made regarding the outcome of any services provided. There is no guarantee, expressed or implied, and no refund of any money paid, due to non-results and/or undesired results due to the counseling you have received. You are encouraged to question the rationale of any services, intervention, and discussion if these seem unclear to you. By signing this document, you give permission for therapy services via telepractice, such as telephone and/or other video conferencing programming (hereinafter "telepractice") to provide an opportunity to communicate with your therapist relative to issues that are non-emergent, non-urgent or noncritical. Therapy is most beneficial with face-

to-face interactions with your therapist, however you may choose to conduct a telepractice session. You understand that telepractice communications are not a replacement for the interpersonal contact that is the basis of the therapeutic relationship. Telepractice has limitations and risks, including but not limited to inherent confidentiality risks of electronic communication and the potential for technology failure. When first initiating a telepractice session that does not include video, I will ensure your confidentiality and protection by identifying you as the client; asking you for demographic information as well as topics covered in our last session. Telepractice via internet-based video conference providers claim to have safeguards in place to protect your personal information from unauthorized disclosure, however you acknowledge that this form of communication may not be completely confidential and there are also the possibilities of viruses, Trojans or other malicious software that may obtain your private information on your computer system and release and/or use your information without your knowledge. Additionally, you acknowledge that there may be other risks associated with telepractice that are unknown at this time. You understand that therapy services via telepractice has limitations, such as lacking the personal face-to-face interactions, lacking visual and audio cues in the therapy process. Additionally, you are aware that most insurance companies will not reimburse the cost of telepractice therapy sessions. You understand that telepractice therapy will not be appropriate if you are experiencing a crisis or having suicidal or homicidal thoughts. If a life-threatening crisis should occur, you agree to call 911 or go to a hospital emergency room. In addressing all of your counseling needs, I reserve the right to terminate our professional counseling relationship and refer you to another counseling resource at any time. Whenever this is necessary, I will attempt to do this in person, however I reserve the right to inform you in writing if necessary.

FEE RATE

The basic fee is **$120 per 45 - 50 minute session** for individual and/or family counseling **with one person** present in session. **Family therapy sessions with two or more** people present is a fee of **$160 per 45-50 minutes** session. Longer sessions (also known as double sessions, about 90 minutes in length) are available and are prorated from those basic fees. The **intake assessment** (first session) is a fee of **$150 per 50-60 minute session**. By signing this document, you agree to pay for all services in full with the knowledge that I do not accept insurance, Medicaid and/or Medicare. If you would like a receipt of services provided for your insurance company, please make me aware of this at the end of the session and a receipt will be provided. Please be advised that there will be a fee charged for any phone call returned to discuss anything other than the changing of appointment times. **Out-of-session phone calls** will be billed at a fee of **$40 for 15 minute increments (other than phone calls to schedule appointment times).** Other work such as written reports or phone consultations with other providers is billed in 15 minute increments at a rate of $40.00/15 minutes. Work done outside of our regularly scheduled appointment will be billed at the time the service is provided. Payment for such work is expected at the time of billing unless otherwise negotiated. If at any point in time you become unable or unwilling to continue paying for my service, I reserve the right to terminate our professional counseling relationship and refer you to another counseling resource. Whenever this is necessary, I will attempt to do this in person, however I reserve the right to inform you in writing if necessary. Any fees that are outstanding may be sent to collections.

PAYMENT METHOD

The client (or responsible party) is considered responsible for payment of professional services. You may pay by **cash or debit/credit card**. Payment is expected at the time services are rendered or before. If payment is not received at the time services are rendered, the debit or credit card on file will be charged for the services. Psychological reports or court reports will not be issued until full payment for services is received. Any fees that are outstanding may be sent to collections.

MISSED APPOINTMENTS

My counseling practice is limited and, as a result, I often refer new clients to other therapists because of the time commitment I've made to you. If you are unable to keep an appointment, please notify me immediately by phone call or email. Text messages are not permitted, as my phone number does not

accept text data messages. Cancellations must be made with 48 hours notice or more (during Monday-Friday business hours) of the appointment date and time. Therefore, if your appointment is Wednesday at 11am, cancellation must occur prior to that Monday, before 11AM. If your appointment is Monday at 11am, your appointment must be cancelled by the Thursday of the week prior before 11am. If an appointment is canceled or missed **without 48 hours prior notice, you will be billed for the missed session at the rate of $75. Third and subsequent late cancellations or missed appointments will be billed the full fee.** When an appointment is cancelled, I will use the 48 hours+ notice to reach out to other clients in order to fill that appointment time.

EMERGENCIES

Emergency situations may arise when you need to speak with me by telephone in-between appointments. Being a practitioner in a group private practice limits my ability to respond to such emergencies in a timely manner. You are entering into our counseling relationship with this understanding and are accepting the level of service I can provide with the implied limitations. Specifically, when I am unavailable, it will be your decision to wait for a return call which may take several days or assume the responsibility to find an alternative source of assistance (in life threatening situations, a call to 911 is your best option). In situations where you do want to speak with me, please call me directly. If I do not answer, please leave a voice message, and as soon as I am available, I will return your call. When I am out of town or otherwise unavailable, my voicemail will typically indicate such. If you are unable to contact me and the situation requires immediate attention due to a mental health crisis, call 911 or go to the nearest ER. Please be aware that most psychiatric hospitals have an emergency evaluation they provide, as do most hospital emergency rooms. Be advised however, that you will be responsible for any and all expenses you may incur by using their services. There are Behavioral Health Crisis Lines available to assist you 24/7/365. All of Maricopa County and Pinal County residents (Zip Codes 85220, 85120, 85240, 85140, 85243, 85143) can call 800.631.1314. Pima County residents can call 800.796.6762.

COURT INVOLVEMENT

Should you become involved in the legal system for any reason, it is important you understand the following: 1) I will not be called upon to furnish my records or testimony until all fees for services and the services of any consultants have been paid in full. 2) In connection with any court appearance, I request that I not be called upon as a witness, nor that you, or your counsel issue a subpoena requiring my attendance on less than twenty days prior notice. I must request this as a condition so as to allow me sufficient time to reschedule other clients. 3) In connection with my attendance in court, depositions and/or any type of expert witness testimony, I am to be compensated at a rate of $350.00 per hour, with a two-hour minimum. This is a port-to-port fee. Expert testimony is defined as any testimony I might provide that has been derived by way of our professional relationship. 4) Any subpoenas requiring my testimony should be accompanied by a check for a minimum of $700.00. All such fees will usually be paid by the party issuing the subpoena, unless otherwise negotiated. 5) In connection with any subpoena request for copies of any part of my records, I request 15 working days advance notice to comply. Additionally, such requests should be accompanied by a check for $150.00. This money will be used to cover the costs of retrieving ($100.00), copying ($0.15/page, $25.00/audio, and $50.00/video) and postage. You agree to pay any additional expenses beyond the $150.00 and I agree to refund any monies not used (there is a $100.00 minimum charge). 6) It is understood that once the aforementioned fees have been paid, I will make every effort to be available if called upon to testify. If it is later determined that my testimony is not required, you understand and agree that none of the prepaid fee will be reimbursed. 7) You agree that under no circumstances shall I be required to attend any court session, or give any testimony in any hearing, or provide my records to any person, until or unless I have been paid in full for all services and the bills of any consultants have been paid in full as well. You agree to instruct your attorney to abide by this requirement as well.

CONSENT

I, voluntarily, agree to receive mental health assessment, care, treatment and/or services and authorize the undersigned therapist to provide such. I understand and agree that I will participate in the planning of these services and that I may stop such care at any time. By signing this consent form, I acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification on anything unclear to me.

__________________________________ ____________

Client Signature **Date**

__________________________________ ____________

Therapist Signature **Date**

CONSENT FOR TREATMENT OF MINORS UNDER THE AGE OF 18

I, am the parent or legal guardian with legal custody of ________________________________
and give permission to provide counseling services to my child(ren) identified above.

______________________________ _________________

Parent/ Guardian Signature **Date**

________________________________ _________________

Minor Client Signature **Date**