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CLIENT CONTRACT

Welcome to my practice! There follows some essential information about psychotherapy. Please read and sign at the bottom to indicate that you have reviewed this information.

PSYCHOLOGICAL SERVICES:

Our first few sessions will involve an evaluation of your needs. This usually lasts between two and four sessions. By the end of the evaluation I will be able to offer you some first impressions of what our work will include and a treatment plan to follow. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money and energy, so choosing a therapist with whom to work should be done with care. Psychotherapy typically involves weekly sessions usually 50 minutes in length. Duration and frequency vary depending on the nature of your problem and your individual needs.

FEE POLICIES

My fee for an individual therapy session is $145. Unless otherwise arranged payment is due at the time of service. Once an appointment hour is scheduled, you will be expected to pay for that hour unless you provide 24 hours notice of cancellation. Exceptions include mutual agreement that you were unable to attend due to circumstances beyond your control. If it is possible, I am happy to reschedule your session at another time. Please be aware that insurance carriers will not reimburse for missed sessions and I will charge you for your copay as well as the amount that insurance would have reimbursed. I accept checks or cash for payments. I do not accept credit card payments unless they are Health Savings Account (HSA) credit cards. I do not accept debit card payments. Fees that are unpaid, or that appear likely to be unpaid, will be discussed with you individually. Please inform me ahead of time or as soon as you know if there are changes in your ability or willingness to pay. Accounts that are not paid within two sessions will be considered delinquent. At that point, if payment arrangements have not been made, I reserve the right to cease routine appointments until the situation is addressed.

INSURANCE REIMBURSEMENT

If you carry mental health insurance coverage, I will bill your carrier and assist with insurance reimbursement. In many circumstances, the insurance carrier limits the fee charged for the session. You will not be charged for the difference between my ordinary fee and the cap placed by insurance. Any copayment necessary should be made at the time of the office visit unless we make other arrangement. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services out of pocket (unless prohibited by contract).

PHONE AND EMERGENCY CONTACT

If you need to contact me by phone, please leave a message on voicemail at my home number (919-302-7416) and I will return your call as soon as possible. I am often not immediately available by telephone. I check messages regularly and will typically get back to you by the end of the day, except on holidays and weekends. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away call Holly Hill Respond (919-250-7000) or the Police Department (911). If you are unable to reach me and need help right away you may also go to your nearest hospital emergency room and ask for the psychiatrist on call. If I will be unavailable for an extended time I will provide you with the name of a colleague to contact, if necessary. Please do not use e-mail for emergencies. I don't always check my e-mail often enough to respond to emergencies.

PHYSICIAN CONTACT

Physical and psychological symptoms often interact. I encourage you to seek medical consultation if warranted. In addition, medication may sometimes be helpful for psychological problems. When appropriate, I can assist you in arranging a referral for mediation evaluation.

CONSULTATION

I consult regularly with other professionals regarding my clients; however, your identity remains completely anonymous, and confidentiality is fully maintained.

CONFIDENTIALITY

(This information is in addition to that detailed in the HIPAA Notice of Privacy Practices 2018 and it is subject to HIPAA pre-emptive analysis)

Information you share with me will be kept strictly confidential and will not be disclosed without your written consent, except when required by law. As mandated by law, confidentiality is not guaranteed (as noted below). If you desire to use your health insurance, identifying information (such as name, phone and address) and procedure and diagnostic codes are transmitted when filing claims. You should be aware that all insurance companies require a clinical diagnosis. I will discuss your diagnosis with you. This information will become part of the insurance company files and will probably be stored in a computer. In some cases they may share the information with a national medial information database. I will provide you with a copy of any report I submit, if you request.

When disclosure is required by law:

Some of the circumstances where disclosure is required by the 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; or
- When client's family members communicate to me that the client presents a danger to others.

When disclosure may be otherwise required:

Disclosure may be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by me. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless I am authorized to do so by all adult family members who were part of the treatment.

In emergencies:

If there is an emergency during our work together, or in the future after termination where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the biographical sheet.

Health insurance and confidentiality of records:

Disclosure of confidential information may be required by your health insurance carrier

or HMO/PPO/MCO/EAP in order to process your claims. Based on your instructions to me, only the minimum necessary information will be communicated to the carrier. I have no control or knowledge over what insurance companies do with the information I submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always uncertain, as computers are inherently vulnerable to unauthorized access. Medical data can in some circumstances be legally accessed by law enforcement and other agencies, which also can put you in a vulnerable position.

E-mail, cell phones, and computers:

It is very important to be aware that computers and e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, my email is not encrypted. My computer is equipped with a firewall, virus protection and a password and I also back up all confidential information from my computer. Please notify me if you decide to avoid or limit in any way the use of any or all communication devices, such as email or cell-phones. Please do not use e-mail for emergencies.

Records and your right to review them:

Both the law and the standards of my profession require that I keep appropriate treatment records for at least 7 years. If a patient was younger than 18 years of age when last treated, I will keep the medical records until the patient reaches age 21 or for seven years from the date of last treatment, whichever is longer. If you have concerns regarding the treatment records please discuss them with me.

As a client, you have the right, which may be restricted only in exceptional circumstances, to inspect your PHI (personal health information) that may be used to make decisions about your care. Your right to inspect your PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. You may request that I provide photocopies, or provide the information in a format other than photocopies. I will use the format you request unless I it is not practical for me to do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting me using the contact information listed in this contract.

If you request photocopies I will charge you $0.35 for each page, $20.00 per hour for my time locating and copying your health information, and add additional charges for

postage if you want copies mailed to you. If you prefer, I will prepare a summary or an explanation of your health information for a lower fee, or I will provide your full record in a digital format, also for a lower fee. Contact me using the information listed in this contract for a full explanation of my fee structure.

LITIGATION LIMITATION

Due to the nature of the therapeutic process and the fact that legal proceedings often involve making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorneys, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

In the event that court or legal issues arise in the course of treatment, a $350.00 fee in the form of a cashier's check will be collected for preparation of medical records and other pertinent documentation required by the court or attorneys. This fee is to be paid one week prior to the service rendered. If I am required to go to court or to complete a deposition, my minimum required fee is $300.00 per hour for eight hours. The payment must be received in the form of a cashier's check.

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE

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. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. I will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia. I may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that may be positive for one family member can be viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, I will likely to draw on

various psychological approaches according, in part, to the problem that is being treated and her assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, cognitive, psychodynamic, existential, family systems, developmental (adult, child, family), humanistic or psycho-educational, Dyadic Developmental Psychotherapy, Somatic Experiencing, EMDR, Play Therapy and Touch Skills Therapy. I do not provide custody evaluation recommendation nor medication or prescription recommendation nor legal advice, as these activities do not fall within my scope of practice.

DISCUSSION OF TREATMENT PLAN:

Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and I will do all that I can to answer your questions. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

TOUCH IN THERAPY:

I may also incorporate non-sexual touch as part of psychotherapy. Sexual touch of clients by therapists is unethical and illegal. I will ask your permission before implementing touch, and you have the right to decline or refuse to be touched without any fear or concern about reprisal. Touch can be very beneficial but can also unexpectedly evoke emotions, thoughts, physical reactions or memories that may be upsetting, depressing, evoke anger, etc. Sharing and processing such feelings with me, if they arise, may be a helpful part of therapy. You may request not to be touched at any time during therapy without needing to explain it and without fear of punishment.

MINOR INFORMED CONSENT:

If you are under eighteen years of age, please be aware that the law may give your parents or guardians the right to obtain information about your treatment and/or examine your treatment records. It is my policy to request a written agreement from your parents or guardians indicating that they consent to give up access to such information and/or to your records. If they agree, I will provide them only with general information about our work together, subject to your approval, or, if I feel it is important for them to know in order to make sure that you and people around you are safe. If I think it is appropriate, I will involve them if I feel that there is a high risk that you will seriously harm yourself or another/others. Before giving them any verbal or written information, I will discuss the matter with you, if possible. I will do the best I can to resolve any differences that you and I may have about what I am prepared to discuss.

By signing this contract you agree that you have been notified that all material discussed during the psychotherapy sessions is confidential and can be released only with the permission of the holder of the privilege.

In case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. By signing this contract you agree to accept my judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the patient's well being.

REFERRALS AND STOPPING THERAPY

After the first couple of meetings, I will assess if I can be of benefit to you. I do not accept clients whom I believe I cannot help. In such a case, I will give you a referral to another therapist. If at any point during psychotherapy, I determine that I am not effective in helping you reach your therapeutic goals, I am obligated to discuss it with you and, if appropriate, stop treatment or refer you to another therapist. If you request it and authorize it in writing, I will talk to the therapist of your choice in order to assist with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified, and if I have your written consent, I will provide them with essential information needed. You have the right to stop therapy at any time. If you choose to do so, I will offer to provide you with names of other qualified professionals who may be of help to you.

HEALTH INFORMATION PRIVACY NOTIFICATION:

I acknowledge that I have been provided with the "HIPAA Notice of Privacy Practices 2018" prior to any services being rendered. I consent to the use and disclosure of my medical information as set forth therein. Print copies are available in my office.

I acknowledge that I have read the above Client Contract carefully; I understand the information included and agree to comply with the policies as stated:

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Client's Name (Print):

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Client's or Guardian Signature **Date**

_____

Client's or Guardian Signature **Date**