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# CLINICAL SERVICES POLICIES AND PROCEDURES

Welcome to my practice. This document contains important information about my professional services and business policies. Individual changes can be made if they are agreed upon in advance. Please note any questions you have and I will be happy to discuss them with you.

**CONSENT TO TREATMENT**
Our psychotherapy relationship is entirely voluntary and you may decide to end it and/or consider alternative modes of treatment any time you wish. While it's expected that you will benefit from the therapy, individual responses vary and you might, at times, experience uncomfortable feelings. Should questions regarding the treatment arise during its course, I encourage you to discuss them with me.

**LENGTH OF SESSIONS**
Initial intake assessments are scheduled for 90 minutes. Psychotherapy sessions are scheduled for fifty minutes. I will be prepared to begin and end our sessions on time.

**FREQUENCY OF SESSIONS**
Sessions are generally once a week, depending on your needs. They may be more or less frequent depending on your current circumstances. Additional sessions can usually be scheduled when the need arises.

**DURATION OF TREATMENT**
There is no standard length of treatment. Duration is based on your individual needs as mutually assessed on an ongoing basis. I practice both short term and long term psychotherapy which can last from weeks to years depending on individual needs. We will assess together what help you want and what that might look like.

**PROFESSIONAL FEES**
The fee for each 90 minute initial intake assessment is $150.00. The fee for 50 minute psychotherapy sessions is $150.00. The fee for a 90 minute family or couples' session is $225.00. I charge $150.00 per hour for any additional required professional services, including: telephone calls lasting longer than 10 minutes, consultations with other professionals you have authorized as a part of your treatment team, letter writing, preparation of records or treatment summaries, report writing, and any other required or requested professional services.

I reserve a limited number of "sliding scale" appointment slots weekly for clients experiencing financial hardship. "Sliding scale" refers to a reduced fee for services based on your income and ability to pay. This fee will be discussed and agreed upon collaboratively if it is deemed appropriate and there are spots currently open.

**PAYMENTS AND BILLING**
You will be expected to pay for each session at the time it is held by cash, check, or credit card. Payment schedules for other professional services will be agreed upon at the time these services are requested.

If your account is more than 30 days in arrears and suitable arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment, including collection agencies or small claims court (If such legal action is necessary, the costs of bringing that proceeding will be included in the claim). In such cases, the only information I would release about a client's treatment would be the client's name, the nature of the services provided, and the amount due.

**HEALTH INSURANCE**
If you carry health insurance, please understand that my professional services are rendered and charged to *you*, not to the insurance company. If you request, I will provide you with a monthly statement which you can submit to your insurance company for reimbursement. This statement will include your diagnosis, the procedure code, the number of sessions, and the amount you have paid me, but for my protection from identity theft I will not reveal my Social Security number to any insurance company. It will be your responsibility to contact your insurance company to determine if it will reimburse you under these terms, and, if so, what percentage of the fee it will cover.

**APPOINTMENTS AND CANCELLATION POLICY**
Please be aware that I will begin and end the hour according to the scheduled time and cannot add time to the end of your hour if you arrive late. In the event of a late arrival you will be charged for a full session. If you need to cancel an appointment, please notify me at least 24 hours in advance. If I do not receive such notice you will be charged for that session. Your insurance carrier will not be responsible for payment under this circumstance.

**TELEPHONE ACCESSIBILITY, EMERGENCIES, E-MAIL, & SOCIAL MEDIA**
I will return calls as soon as possible or within 1 business day, should you need to speak with me between sessions. I can be reached if you do not feel it can wait until our next session, but this is not designed for life-threatening emergencies or therapy by phone. Should a phone contact exceed 15 minutes, it will be considered a full therapy session and you will be billed accordingly. Please note that while I will attempt to contact you as soon as possible, I do not provide formal emergency services. In a life-threatening situation you should either call 911 or the Florida Crisis line at 211. You can also go directly to a hospital emergency room for evaluation. If I will be unavailable for an extended time, I will provide you with the name of a qualified colleague to contact if necessary.

I do not correspond with clients by e-mail as it is not a secure means of communication.

I also do not accept friend/contact requests from former or current clients on any social media site (e.g., Facebook, Twitter, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It also has the potential to 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.

**MINORS**
Patients under 18 years of age (who are not legally emancipated) and their parents should be aware that the law may allow parents to examine their child's treatment records. Children between 13 and 17 may independently consent to (and control access to the records of) diagnosis and treatment in a crisis situation. Because privacy in psychotherapy is often crucial to successful progress, and parental involvement is also essential, it is usually my policy to request an agreement with minors and their parents about access to information. This agreement provides that during treatment, I will provide parents with only general information about the progress of the treatment, and the patient's attendance at scheduled sessions. Therapists can also provide parents with a summary of their child's treatment when it is complete. Other communications are kept to a minimum unless the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

**PROFESSIONAL RECORDS**
The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. I am required to keep written treatment records. You are entitled to review and/or receive a copy of the records unless I believe seeing them would be emotionally damaging. In this case I would be happy to summarize them

and/or send them to a mental health professional of your choice. Because they are professional records and might be written in technical language I suggest your review be done in my presence so that we can discuss the contents and I can answer any questions you might have. In most circumstances, I charge a copying and administrative fee of $1.00 per page.

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.

**CONFIDENTIALITY AND LIMITS**

Therapy sessions between a psychologist and client are confidential and release of Protected Health Information requires your written permission, except under certain legally defined situations:

- If I become aware that a client intends to harm him/herself, harm another, or if s/he is unable to provide self-care at a level necessary for basic survival, I am ethically and legally bound to take appropriate action to protect against such dangers.
- State law requires the report of suspected child, vulnerable adult, or otherwise dependent abuse or neglect when there is reasonable belief that it has occurred.
- Under the US Patriot Act, I am required to release records if requested by the federal government if a client is suspected of involvement in terrorism.
- In response to a court order, I may have to release records or testify.
- If you are utilizing an insurance company to reimburse you for out-of-network benefits, you will be required to consent to the release of information such as your clinical diagnosis, and your records may be reviewed.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- 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.
- Regarding collection situations (see payment section above), I am permitted to release your name, the nature of services provided, and the amount due.
- Finally, on occasion to benefit the treatment, I may consult with another clinician.  This is done with great respect for your privacy and identifying information is omitted whenever possible.

**PATIENT RIGHTS**

HIPAA provides you with several new or expanded rights with regard to 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.

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.

Signature: ____________________________________ Date: ________________________________________

Printed Name: ________________________________