Heart Centered Healing Connections

Policies, Procedures and Consent Form

Welcome! This document contains important information. It is intended to inform you of my professional services, your rights, policies, and State and Federal Laws.

Therapy

The goal of therapy is to help you identify and learn ways to cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. Both the client and the therapist make a commitment to working together to establish Goals that reflects the desires and needs of the client(s).
I understand that the benefits of therapy may include a better understanding of myself and may enhance my ability to handle and cope with issues and relationships. I have been given the opportunity to ask questions and receive satisfactory answers and to participate in my treatment plan. I understand there is no guarantee to positive results or length of treatment plan and that I may discontinue treatment at any time. If I feel your needs are beyond what my services can provide for you I will be happy to refer you to another mental health professional. Your progress in therapy often depends much more on what you do between sessions than on what happens in session.

Initial here: _____

Appointments

Appointments are usually scheduled for 50 minutes. Sessions may be scheduled for 25 or 75 minutes. Telephone Counseling sessions may be scheduled. Clients are usually seen weekly or more/less frequently as appropriate. You may discontinue treatment at any time, but please discuss this important decision with me.

Initial Here: _____

Cancellations and Missed Appointments

You will be billed $75.00 for a session that you cancel (or Do not show for) with less than 24 hours notice. You may leave messages 24 hours per day. Please note that insurance companies generally do not reimburse for failed appointments so you will be responsible for this expense personally.

Initial here: _____

Emergencies

In between sessions, In the event of an emergency please choose one of the following:

1. Call 911, 211, or visit your local emergency room.
2. Contact the mobile crisis unit at 383-5777 (North of Southern Blvd.) or 637-2102 (South of Southern Blvd.).
3. Contact your psychiatrist or general practitioner.

Initial here: _____

Record Keeping

A clinical chart is maintained describing your condition, treatment, progress, dates and fees for sessions, and notes about each therapy session. Your records will not be released without your written consent, except as outlined in the Confidentiality section below.

Initial Here: _____

Limits of Confidentiality/Legal

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include but are not limited to:

1. The client authorizes a release of information with a signature.
2. Suspected abuse or neglect of a child, elderly person, or a disabled person.
3. The client presents as a physical danger to self or to others.
4. If you report that you intend to physically injure someone the law requires me to inform that person as well as legal authorities.
5. If I am ordered by a judge/ court to release information.
6. Your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc.
7. In natural disasters whereby protected records may become exposed.
8. When Otherwise required by LAW.

If you are under 18 years of age please be aware that the law provides both parents and or guardians the right to information regarding your treatment. It is my policy to request an agreement from parents /guardians that they allow our sessions to remain confidential. Absent such a guarantee of confidentiality, your child or adolescent may not trust me enough to establish a therapeutic relationship and treatment will be less effective. If the parents/guardian agrees I will provide them only with general information about our work together unless I feel there is a high risk that you will harm yourself or someone else. In this case I will notify them of my concern. I will also provide them a summary of your treatment when it is complete. Before I give them any information I will discuss the matter with you, if possible, and do my best to handle any objections you may have about what I am prepared to discuss.

9. I may find it helpful to consult other professionals about a case. During a consultation your identity will not be revealed and my professional peers are likewise bound by confidentiality.

10. If your account becomes overdue and you do not pay the amount due or work out a payment plan, I will reveal a limited amount of information about your treatment in taking legal measures to be paid. This information will include your name, social security number, address, dates and type of treatment and the amount due. If any accounts are more than 90 days past due, I will add a 10% interest charge each month thereafter.

11. Please be advised that confidentiality cannot be guaranteed when communication utilizes technology. I.e., telephone, internet.

Initial here_____

Legal/Court

It is the opinion of this licensed professional that the relationship between the therapist and her client is for therapeutic purposes only. Therefore, in the event you are involved in divorce, child custody, or other legal matters, you agree that you will not have me subpoenaed to provide testimony or to provide any written documentation that would break this confidentiality. However, if you choose to waive this confidentiality agreement, you recognize that all information exchanged in confidence shall be open to the court for examination and therefore, you cannot hold this therapist at fault for any reason, including but not limited to a judgment against the undersigned client. You also understand that any time spent on giving depositions or testimony, answering phone calls from attorneys, and any other work related to these legal proceedings, will be billed to the client for compensation.

Initial here_____
or
Waive Confidentiality/Agree to compensation for legal time_____
(complete waiver form)

Fees/Payments (Subject to change annually)
My fee for a 45 minute session (90834) is $125.00 and $65.00 for a 25 minute session (90832). Anything over 50 (not to exceed 70 minutes) will be charged at $150.00 (90837).
The Standard Fee for phone consults over 10 minutes: $2/Minute
Payment is due at each session, unless prior arrangements have been made.

Initial here_____

DISCHARGE

There is an office policy that if there is no contact within a 90 day period of time, your case will be closed.

Initial here_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

I have read and received a copy of the Notice of Privacy Practices and Client Rights documentation.

Initial Here: _____

Contact

I agree to be contacted on phone numbers on file. **Initial Here**____
I agree to be contacted by email /text. **Initial Here**____
I agree mail may be sent to the address on intake form. **Initial Here**____

Consent for Treatment

By signing below, you are stating that you have read and understood this policy statement and have had your questions answered to your satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. I understand that I may withdraw from treatment at any time.

Signature_____ Date_____

Name Printed_____ Date_____

Parent/Guardian Signature_____ Date_____

Name Printed_____ Relationship to Client_____

Therapist/Provider_____ Date_____