**Ben Geilhufe Psychotherapy**
Ben Geilhufe, MA, LPCC
Licensed Professional Clinical Counselor #3670
1406 Mission St., Santa Cruz CA 95060
206-679-7218
www.bengeilhufe.com

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## AGREEMENT FOR SERVICE / INFORMED CONSENT

*Please initial each page and sign/date at the end of the document.*

This is an agreement for psychotherapy services between Ben Geilhufe, LPCC and _____ Legal Name of Client).

### Psychotherapy

Psychotherapy has both benefits and risks. The risks may include experiencing uncomfortable feelings such as sadness or anger. It often requires discussing difficult aspects of your life. The majority of individuals who participate in therapy benefit from the experience. Therapy often leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems. However, there are no guarantees about what will happen or about how successful your experience will be. Therapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss both during our sessions and at home.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work will include and an initial treatment plan to follow. You should evaluate this information and whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be careful about the therapist you select. If either of us feel that we are not a good match for therapy, I will be happy to help you find another therapist who may be a better fit for your needs. If we agree to work together, I usually schedule one session per week.

### Confidentiality

The information disclosed by you is generally confidential and will not be released to any third party without your written authorization, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, reporting child, elder and dependent adult abuse, when a client makes a serious threat of violence towards a reasonably identifiable victim, or when a client is dangerous to him/herself or to another person. I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding clients unless I have a specific written release to do so.

For the purpose of serving you well and to meet legal requirements, I keep a clinical file for each client. If you would like to see these records, a request must be made in writing. I reserve the right, under California law, to provide you with a treatment summary in lieu of actual records, and/or provide a copy of the record to another treating health care provider. I will maintain your records in confidentiality for ten years following therapy.

**Client Litigation and Psychotherapist-Client Privilege**

I will not voluntarily participate in any litigation, or custody dispute in which you and another individual, or entity, are parties. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving a client, clients will reimburse me for any time spent for preparation, travel, or other time in which I make myself available for such an appearance at an hourly rate of $200/hour, with a 4 hour minimum fee.

The information disclosed by you in therapy, as well as any records created is subject to the "psychotherapist-client privilege." If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert this privilege on your behalf until instructed, in writing, to do otherwise by you or your legal representative.

**Fees**

My full fee for service is $150 per 50-minute session. If you are late, we will end on time and you will be responsible for the full 50-minute fee. If I am late, you will still be given 50 minutes of my time for the session. I reserve the right to periodically adjust this fee with advance notice to my clients. This fee may be adjusted by contract third-party payers, or by agreement with the therapist.

You are responsible for paying for your session weekly unless we have made other arrangements in writing. If we schedule a session for longer than 50 minutes, I will bill you prorated on the hourly fee.

Emergency phone calls of less than ten minutes are normally free. Telephone sessions in excess of 10 minutes are billed on a pro rata basis. School visits, IEP meetings, or other professional consultation at the request of the client will be billed at the agreed upon hourly session rate

Any overdue bills will be charged 1.5% per month interest. If you eventually refuse to pay your debt, I reserve the right to give your name and the amount due to a collection agency.

**Insurance**

I am only in network with Anthem Blue Cross and Anthem UCSHIP. I may not be able to process insurance claims if you have Anthem Blue Cross or UCSHIP as well as another insurance policy. It is your responsibility to identify your insurance coverage with your insurance plan and to disclose all insurance plans to me. By signing this consent form you acknowledge that Ben Geilhufe is not responsible in any way for billing insurance companies other than Anthem Blue Cross or UCSHIP, nor will Ben Geilhufe be responsible for submitting reimbursement to Anthem Blue Cross/UCSHIP if Anthem Blue Cross/UCSHIP determines, at any point in treatment or after treatment, that they require reimbursement for any reason. You accept full responsibility for any reimbursement requested by Anthem Blue Cross and Anthem UCSHIP throughout and after the course of treatment with Ben Geilhufe. If Anthem deducts payment from Ben Geilhufe in any way due to claimed "overpayment" on your account, you are responsible for paying the deductions back to Ben Geilhufe, whether you are an active or inactive client. You understand that if, at any point in treatment, you obtain another insurance plan you must disclose this information to Ben Geilhufe immediately, and understand that this may impact insurance coverage of treatment with Ben Geilhufe through Anthem Blue Cross and/or Anthem UCSHIP.

**No Secrets Policy**

If you participate in conjoint therapy, I will not disclose confidential information about your treatment unless all person(s) who participate in treatment provide their written authorization to release information. I practice a "no secrets" policy when conducting conjoint therapy, which means I will not hold secrets disclosed by one party from others involved in treatment.

**Cancellation Policy**

Cancellation notice should be left on my voice mail at 206-679-7218. You are responsible for payment of agreed upon fee for any missed session(s) for which you did not give me at least 24-hour notice of cancellation. Insurance does not provide reimbursement for missed sessions - you are responsible for the full fee. Payment for missed sessions is due at the next regularly scheduled meeting. If canceling by email, you must receive confirmation by phone or email that I have received the cancellation in order for the session to not be counted as a missed session.

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## Therapist Availability

I will make every effort to return calls as soon as possible. I do not return calls on weekends and holidays. All requests for clinical therapeutic communication should be made via voicemail, rather than email. Please let me know if a special arrangement needs to be made regarding communication. In the event that you are feeling unsafe or require immediate medical or psychiatric assistance, please call 911.

## Complaints

If you are unhappy with what's happening in therapy, I hope you'll talk about it with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. I can be reached at: 206-679-7218.

## Acknowledgement

By signing below, I acknowledge that I have reviewed and fully understand and will abide by this agreement and consent to participate in psychotherapy with Ben Geilhufe. I have read and understood the notice of "Health Information Practice and Privacy Policies" which describes rights regarding Protected Health Information (PHI) as a participant with Ben Geilhufe Psychotherapy per federal HIPPAA requirements. I agree to hold Ben Geilhufe free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from psychotherapy treatment. I understand that I am financially responsible to Ben Geilhufe for all charges.

Client Legal Name (please print) _____

Signature of Client _____ Date:_____/_____/_____
(or authorized representative/parent or guardian)

Signature of Client _____ Date:_____/_____/_____
(or authorized representative/parent or guardian)