THERAPIST/CLIENT SERVICES AGREEMENT

This document contains important information about my professional services and business policies. It also contains your Client Rights and summary information about the Health Insurance Portability and Accountability Act (HIPPA) in the Notice of Privacy Practices. I am required by law to obtain your signature acknowledging that I have provided you with this information at the first session. Please read this document carefully and ask me any questions you may have. When you sign this document, it will represent an agreement between us. This is your informed consent.

Client Rights

1. You have the right to request information about your therapist's qualifications, credentials, experience, specialization and education.
2. You have the right to obtain from another therapist a second opinion regarding the assessment and treatment plan developed to assist with your presenting problem.
3. You have the right to ask for an alternative referral at any time.
4. You have the right to inquire about fees for therapy, billing practices, insurance reimbursement, and other methods of payment.
5. You have the right to terminate therapy when you have reached your goals or believe therapy is no longer necessary.
6. You have the right to refuse the suggested intervention or treatment strategy indicated by your therapist.
7. The frequency and duration of therapy depends on many factors. It is your right to be part of determining jointly with your therapist how long and often you will receive therapy.
8. You have the right to renegotiate therapy as often as needed.
9. You have the right to receive complete and accurate information regarding your diagnosis, treatment, risks and prognosis.
10. While exploring personal issues and making life changes you might experience emotional pain, discomfort and anxiety. You have the right to decide what to talk about and work on in and out of therapy. Nevertheless, your active participation will have the greatest positive effect on the outcome of therapy.
11. You have the right to confidentiality, unless you report to be in danger to yourself or others (Therapists must report to appropriate agencies if you are suicidal or homicidal). Limits also include misconduct of other mental health professionals, suspected abuse of children and vulnerable adults, prenatal exposure to controlled substances, court ordered reports, potential use of a collection agency, and insurance agencies. In these situations, there are limits to confidentiality.
12. If you are a minor, you have the right to request that data about you be kept from your parents. This request must be in writing. The request must include reasons for withholding information from parents.
13. If you are parent of a minor child, you have the right to access information unless a written request has been made by your child to deny access to information.
14. You have a right to see your file.

In addition, HIPAA provides you with rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an account of most disclosures of protected health information 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 and my privacy policies and procedures.

Professional Fees

1. Fifty-five (55) minutes of family, couples, or individual therapy: $90
2. Full fee is expected at the time of service.
3. Cancellations made with less than a 24-hour notice and failure to show for an appointment may be subject to a full charge of $90
4. Payment may be made with cash or check to Both/And Resources

Contacting Me

To schedule an appointment with me please call (651) 785-3660. Since I am often seeing other clients you may reach my voicemail. Please leave me a message with your phone number and a good time to reach you. When I am in the office, I check my messages throughout the day. On days that I am not there, I usually check at least once during the day. The exceptions to this are on weekends, holidays, or when I am sick or on vacation.

*If you cannot reach me in an emergency, visit an emergency room, call 911, or call the ***Crisis Connection at*** **(612) 379-6363.**

Limits on Confidentiality

In most situations, I can only release information about you to others if you sign a written authorization form that meets certain legal requirements. Other situations require only that you provide written, advance consent. Your signature on this agreement provides consent for the following activities:

- Consultation with other health and mental health professionals during which I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential.
- I also may have contracts with secretarial services, billing services or accounting services. As required by HIPAA, I will have a formal business associate contract with these businesses in which they are required to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.
- Disclosures required by health insurers as applicable.

There are other situations in which I am legally obligated to take actions such as in cases of possible child abuse, neglect or self-harm. These limits and uses are detailed further in the Notice of Privacy Practices.

_____ _____ _____ _____

Signature *Date* *Signature* *Date*