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CLIENT-THERAPIST AGREEMENT

You have chosen to enter a therapeutic relationship with me. This agreement consists of a summary of Office Policies, Costs Outside of Customary Services Provided, and a Confidentiality/HIPPA Statement. Kindly review it and sign the bottom of the agreement (on the back of this page) to let me know you understand and agree with all these statements.

GENERAL POLICIES

- Unless otherwise noted, this process is *voluntary*. You may, at any time, withdraw from the process. During your course of our time together, please provide me with feedback. If a client feels a lack of direction, it may become evident through a lack of progress or withdrawal in other ways, such as missed appointments or ending therapy altogether. The only way I can tell if therapy is useful to you is through your own voice.

- Please arrive promptly at the time of your scheduled appointments; generally speaking, I will not be able to extend sessions. Please note that fees/co-pays are expected at the time of the service provided. If you consistently fail to pay your fee/co-pay, I may suspend our meetings until you are current with payment.

- CANCELLATION POLICY: If you are using insurance, I cannot bill insurance companies for missed appointments. If you are unable to make an appointment, please give at least 24 hours' notice by calling my office or contacting me through my website at www.therapyforachange.com. My policy is to charge $70 for missed sessions or for sessions cancelled within 24 hours of the scheduled appointment, except in the case of a personal or family emergency. I will make every effort to contact you within one business day to reschedule.

- I will make every effort to protect your privacy. Because my practice is in a relatively small community, if I should see you outside the office, I will not approach you unless you let me know that it is okay. Information regarding our therapeutic relationship will be shared only in certain circumstances, with your permission. For a more complete review of the privacy guidelines, refer to the Confidentiality/HIPPA Statement (on back of this page).

- ELECTRONIC MEDIA POLICY: The confidentiality of information you decide to share over email or text cannot be fully protected or guaranteed. If you choose to accept texts or emails from me, precautionary steps to protect your privacy/confidentiality will be in place but cannot be guaranteed.

- COSTS OUTSIDE OF CUSTOMARY SERVICES PROVIDED: Occasionally, clients may request reports and treatment summaries to be provided to other professionals or providers. Again, this will only be done with your written permission. Insurance carriers do not pay for such services; therefore, my charge to clients for any services provided outside of the usual and customary is $125.00 per hour. If I am called to testify in court proceedings, my charge to clients is $300.00 per hour, which includes travel time.

- SUPERVISION: In order to provide you with the best therapeutic services I can, and to continue learning and growing as a therapist, I may use your case material in supervision with supervisors and/or peers. In these cases, every effort will be made to protect your identity. Additional information regarding confidentiality is discussed on the back of this agreement.

TELEHEALTH CONSENT

This section contains important information about participating in Telehealth Services. For the purposes of this document, Telehealth refers to using telecommunication technologies in the provision of mental and behavioral health services. This may include, but is not limited to, interactive videoconferencing, as well as communicating via telephone, text, and email.

Risks and Benefits of Telehealth Services

There are several risks and benefits to using Telehealth Services that need to be weighed by both the clinician and client prior to using these services. The most salient benefit to using telehealth services is it allows access to care when it is not possible or extremely inconvenient to travel to an office location. Telehealth also allows continuity of care when a client or clinician moves to a different location, during extended vacations or illnesses, or during public health or weather-related emergencies. Using phone or text messaging, as well as email, to communicate between sessions is very convenient and assists with continuity of care.

Potential risks related to Telehealth Services include risks to confidentiality. Because the communications are taking place via the internet, it is possible that other people might be able to access private conversations or stored data. I will minimize this risk for videoconferencing services by using a HIPAA compliant platform (doxy .me). In addition, there is potential for others in your household or environment to overhear your conversations. You can minimize this risk by engaging in sessions only from a private place where others are not present.

Early research suggests that interactive videoconferencing is equal in effectiveness to in-person sessions. However, videoconferencing may not be appropriate for all clients given personal preferences and/or certain diagnostic or therapeutic needs. There may be some difficulties fully understanding one another's non-verbal cues over videoconferencing or phone conversations. There is also a high risk of miscommunication via text messaging and email because tone of voice and nonverbal cues are nonexistent. There is also the risk of autocorrection changing the meaning of the messages.

Another risk is related to technological difficulties which can impact communication. For example, technology might freeze or stop working during a videoconferencing session. There may also be difficulties connecting or delays in appointment times. Telehealth will require a certain amount of technical competence, a lack of which may increase problems using technology.

Emergencies and Crisis Management

Telehealth Services are not appropriate during mental health crises or emergencies, such as when a client is experiencing suicidal or homicidal thoughts or plans. Evaluating the need for emergency care may be more difficult when using Telehealth technologies. Thus, you will identify an emergency contact person, who is near your location, that I could contact in the event of a crisis or emergency. I may also need to call the local police or 911 if I feel that your safety is at risk. Because it is more difficult to assess emergencies when using Telehealth Services, there is a higher risk that I may err on the side of caution and contact your emergency contact or the police during a crisis, even if it was not warranted.

Informed Consent

By initialing below this section, I indicate that I have read, understand, and agree with the terms of this Telehealth Services section. I have had the opportunity to ask questions and receive clarification on anything I do not understand. I agree to provide the name of an emergency contact and to give my location prior to beginning each session so that police may be contacted in case of an emergency. Furthermore, I understand that Telehealth Services may not be deemed appropriate for me, now or anytime in the future, and I may need to attend in-person sessions to continue my care.

Client 1 Initials _____ Client 2 Initials _____

CONFIDENTIALITY/HIPAA STATEMENT

There are federal and state laws that protect your right to confidentiality regarding your participation in therapy with me. Without your written permission, I cannot discuss any information you share with me with another person or agency. The following are circumstances in which I do not have to adhere to the above regulations:

- DUTY TO WARN AND PROTECT: If a client reports an intention to harm him/herself or others;
- ABUSE OF CHILDREN AND VULNERABLE ADULTS: If a client reports or suggests that a child or vulnerable adult is being or has recently been abused, or it is suspected they may be abused, or is in danger of being abused;
- PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES: If a client admits prenatal exposure to controlled substances that are potentially harmful;
- MINORS/GUARDIANSHIP: If a parent or legal guardian of non-emancipated minor clients request access to the client's records;
- COURT ORDER: If I am required to provide records or information by a court order.

INSURANCE: By signing this agreement, I have your permission to provide protected health information to your insurance carrier, HMO, or billing office to procure payment for services rendered. Information that may be requested includes types of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries. Also, it is your responsibility to inform me of any changes to your insurance benefits as they occur.

I welcome the opportunity to work with you on a personal level. I consider it an honor to enter a therapeutic relationship with you and look forward to hearing about the work that gets done *outside* the therapy office, between our sessions.

My (the client's) signature(s) below indicates that I understand and agree with all statements in this Client-Therapist Agreement and that I consent to treatment with Elena Schreiber, LMFT. (In the case that a minor child/teenager (under 18 years old) is receiving treatment, I consent for my child/teenager to obtain treatment.)

_____	_____	_____
Print Client Name	Client Signature	Date Signed
_____	_____	_____
Print Client Name	Client Signature	Date Signed
_____	_____	_____
Print Parent/Guardian Name (if client is under 18)	Parent/Guardian Signature	Date Signed

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's (and/or people's) behaviors and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Elena Schreiber, LMFT	_____	_____
Print Therapist Name	Therapist Signature	Date Signed

This is a strictly confidential client medical record. Redisclosure or transfer is expressly prohibited by law.