Patricia M. Castellanos, LMHC, C.Ht

Licensed Mental Health Counselor and Clinical Hypnotherapist

Policies and Procedures

This document contains important information about my professional services, policies, procedures, informed consent, telehealth. As a client, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. As your therapist, I have corresponding responsibilities to you. These rights and responsibilities are described in the following sections. You will be provided with a document containing information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. At the end of this document, you will have the opportunity to acknowledge receipt of the Notice of Policies and Privacy Practices. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will represent an agreement between us. If you have any questions, please reach out to discuss them with me.

Practitioner:
Patricia M. Castellanos LMHC, CHt, HBCE provides Psychotherapy & Hypnotherapy to Women & Mothers. Ms. Castellanos earned her Master's degree in Mental Health Counseling from Nova Southeastern University and is licensed in the State of Florida, and has been practicing for over 10 years as a Psychotherapist. She is certified in Clinical Hypnotherapy, HypnoFertility and HypnoBirthing Childbirth Education. During her extensive career, she has focused on assisting clients with life transitions, motherhood, parenting, relationships, depression, anxiety, stress management and general life challenges. She has worked with a diverse and bilingual English and Spanish population and maintains a culturally competent practice. Her approach utilizes hypnosis, empowerment and positive interventions with evidence based models of practice and therapeutic approaches to build on your strengths and insight. Through Individual work, HypnoBirthing classes and workshops, she is innovative and creative in her approach to helping clients find the clarity and understanding to reach their goals. She is an active member of the International Association for Counselors, Therapists and International Certification Board of Clinical Hypnotherapists and HypnoBirthing International.

Sessions:
A 30 minute complimentary initial consultation is provided. After the initial consultation, the most appropriate package is determined for the client based on needs and goals. Regular sessions are 60-90 minutes. Additional sessions can be arranged if it is determined by both the client and therapist to be beneficial. Client must complete New Client Paperwork prior to beginning services. Please be aware that if you are late for a session, it will still end at the scheduled time, as there may be other clients scheduled after your session.

Professional Fees:
The standard service fee is $200 for regular sessions. Packages available in increments of a single session, 2 sessions or 4 sessions. Specialized Hypnosis services, workshops and classes have specific fees. All fees and payments are described and discussed at consultation. Payment plans are available via credit card authorization. The fees may be revised from time to time, and a revised copy will be provided to you. Any agreed upon fees are firm for the duration of the services up to discharge or if you chose to discontinue services. Accepted payment methods include: Paypal, Zelle and major credit cards. You are responsible for payment as agreed upon at consultation. A record of payment for all services provided will be kept in your chart. Any returned check are subject to an additional fee of $30.00, per occurrence, to cover the bank fee incurred. If you refuse to pay your debt, a letter will be mailed out stating services will be suspended and we reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is our practice to charge $150 per hour on a prorated basis (we will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request. This will be billed or charged to the credit card on file.

Insurance:
I am a self-pay provider and therefore not a provider on insurance panels. Some benefits of self-pay include, flexibility in treatment approaches, no diagnosis requirement to receive services, no session limitations or requirements and maintaining privacy in reaching your goals. If your insurance accepts out-of-network claims, I will provide a Super Bill upon request for your reimbursement submission at your discretion. Therapist holds no responsibility for insurance billing. Client understands that payment of professional fees for service are self-pay and due as agreed upon.

Missed Appointment and Cancellation Policy:
Once we begin working together, we set aside time specifically for you. Please reserve cancellations for emergencies and illness only, as progress is stronger with consistent sessions. If you need to cancel or reschedule a session, notice must be made least 24 hours in advance. If you miss your scheduled appointment and you have not notified us at least 24 hours in advance, you will be required to pay the session fee in full. This fee will automatically be charged to the credit card on file. The missed session will not be lost, it will remain on file to be rescheduled. Sessions are forfeited after 6 months of nonattendance.

Contact and Emergency Procedures:
You may contact me via telephone. I am often not immediately available by telephone as I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. I will make every effort to return your call within 24 hours of when it was made, with the exception of weekends and holidays. This is not a crisis facility. If, for any reason, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, in case of crisis or emergency, call 911 or go to the nearest emergency room or hospital. I will make every attempt to inform you in advance of planned absences, and provide you with alternate professional contact information in case of urgent need.

Other Rights:
If you are unhappy with what is happening in therapy, I encourage you to speak with me so I can respond to your concerns. These comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and may end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination of race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You may ask questions about any aspects of therapy and about my specific training and experience.

Informed Consent

Confidentiality:
Your confidentiality and privacy is of the utmost importance. It is what guides our practice and allows the professional relationship to build trust and promote growth and fulfillment of your individual goals. No information will be released or obtained to or from any source, without your prior written consent. Your personal information is protected through HIPPA, ethical and legal standards of practice between a client and counselor. This form does not cover every possible exception. Please refer to the provided HIPPA Notice of Privacy Practices for more information on your confidentiality.

Limits of Confidentiality:
- If there is a reasonable suspicion of abuse/neglect of a child, elderly, dependent, or disabled person, I am required to report this to the appropriate authorities immediately.
- If you may be in danger of harming yourself, I will make every effort to work with you to ensure your safety. However, if you do not cooperate, additional measures may need to be taken.
- If you may be in danger of harming another person, I am required to notify the police.
- As required by a third-party to obtain reimbursement
- As otherwise ordered or required by law (for example, as a result of a court order)

Court and/or Legal Proceedings:
I do not provide testimony or representation in court. There are also some situations in which we are permitted or required to disclose information without either the consent or authorization of a client. If you are involved in a court proceeding and a request is made for information concerning your diagnosis or treatment, such information is protected by the therapist-client privilege law. We cannot provide information without your (or your legal representative's) written authorization, or court order/subpoena. If you are involved in or are contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

Confidentiality and Consultation with Professionals:
I may occasionally consult with other health and mental health professionals about a case. In each case I will make sure to disguise personal identities and I will not use identifying information, reveal your name or things about you that could lead someone to know who I am discussing. All professionals are also legally bound to keep information confidential.

Professional Records:
I am required to keep appropriate records of the counseling services I provide. Your records are kept in a secure location in my office. Your records contain information noting your attendance, reasons for seeking counseling, treatment goals and progress. Additionally, any information that is obtained from providers (I.e. counselors, psychiatrists, doctors, school personnel), copies of records sent or received to/from other providers (when applicable), and billing records. You have the right to a copy of your file except in unusual circumstances that involve a danger to yourself. Clinical notes are protected by HIPPA and therefore upon request for records, a summary of clinical notes will be provided. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend you review them with me or forward them to another mental health professional to discuss its contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider. Your written request and consent is required for any records release.

Indemnification and Release of Liability:
Through the clinical process, the counselor and client work together in order to seek an understanding to the meaning of emotions, thoughts, situations, dreams, desires, and physical and social reactions. Through this process, unfamiliar or uncomfortable feelings may arise. This, however, is an expected, normal and sometimes necessary part of the counseling process. You will work together with the counselor in order to identify your goals and explore what it is that is creating barriers to those goals. The process of expression is a part of growth and healing that often leads to improved relationships with yourself and others, solutions to your specific problems, and significant reductions in feelings of block or distress. As this process is an individualized and collaborative effort between client and counselor, fully discussed and agreed upon, you agree to indemnify and hold harmless Patricia M. Castellanos, LMHC, C.Ht, HBCE from all liabilities and claims which may arise as a result of my participation in services.

Telehealth Informed Consent

I hereby consent to participating in telehealth with Patricia M. Castellanos, LMHC, C.Ht, HBCE as part of my psychotherapy and/or hypnotherapy. I understand that telehealth is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications between a practitioner and a client who are located in two different locations. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to health care practitioners located in Florida or outside of Florida, when applicable and appropriate.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

(4) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

(5) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

(6) I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

(7) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.

(8) I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable toto discuss since we may reconnect within ten minutes, please call me at 305-562-3699 have to re-schedule.

(9) I understand I have a right to access my medical information and copies of medical records in accordance with Florida law.

(10) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Acknowledgement:

I _____ acknowledge that I have read the information provided above in this agreement, I have discussed it with my therapist, and all of my questions have been answered to my satisfaction. I acknowledge that I understand the above information. I accept and consent to participate in services.

Client Print (Primary)	**Client Signature**	**Date**
Client Print (Other)	**Client Signature**	**Date**
Practitioner Print	**Practitioner Signature**	**Date**

ACKNOWLEDGEMENT OF RECIEPT OF
NOTICE OF POLICIES AND PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS DOCUMENT.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Mental Health Practitioners' Policies & Privacy Practices including Health Insurance Portability and Accountability Act (HIPAA) to protect the privacy of your health information. A copy of this signed, dated Acknowledgement shall be as effective as the original. If you have any questions about this form or the Notice of Mental Health Practitioners' Policies & Privacy Practices please reach out to discuss it further.

Client Print (Primary)	**Client Signature**	**Date**
Client Print (Other)	**Client Signature**	**Date**
Practitioner Print	**Practitioner Signature**	**Date**