

ORANGE COUNTY CHRISTIAN THERAPY at The Haven
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PSYCHOTHERAPIST-CLIENT SERVICE AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, 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. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

Typically, the first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I am able to offer you some initial impressions of what our work might include. In this case, however, you are choosing to participate in time-limited brief therapy and, since you do not live in the area and I do not provide long distance tele-therapy you may find that our therapy session serve only to uncover and increase some awareness of troubling issues for you and that longer term follow up therapy may be recommended by me.

Because your residence in another state, I am unable to make any specific recommendations of other therapists in your area who provide care, but I will be able to make general recommendations of how to find a suitable therapist close to your home.

In longer term therapist, following my initial evaluation, we would discuss your treatment goals and create an initial treatment plan. In this case, since we are agreeing to time-limited brief therapy, rather than an overall treatment plan, we will instead focus on one or more issues in each session that you have identified as targets for our time together and I will assign you "homework" exercises between sessions which may be as frequent as daily during your stay at the retreat center DBA "The Haven Spiritual Retreat Center" in Orange, California.

APPOINTMENTS

Appointments will ordinarily be 60 minutes in duration, no more often than one session per day at a time we agree on. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect the amount of the agreed upon fee. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES

The standard fee for the initial intake is \$150.00 (a 90 minute session) and each subsequent session (60 minutes) is \$100.00. You are responsible for paying at the time of your session unless prior arrangements have been made. In this case, you will pay a total sum at the end of your time at The Haven and our final therapy appointment. Payment must be made by check, cash or Venmo electronic transfer; I am not able to process credit card charges as payment. Any checks returned to me for non-sufficient funds are subject to an additional fee of up to \$25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

INSURANCE

In this type brief time-limited therapy, I do not bill or provide any sort of claim worthy documentation for insurance companies. I will not be supporting you in filing claims with your insurer. By signing this document, you agree that you understand that this is a cash pay only agreement.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have

them forwarded to another mental health professional to discuss the contents if you intend to obtain copies. 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 at your written request.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

CONTACTING ME

I am often not immediately available by telephone. 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 or send me a text requesting a phone call and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, 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, call 911 or visit a local hospital emergency room.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I help you find another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

Signature of Patient/Client

Printed Name of Patient/Client or Personal Representative

Date _____