SOMATIC LATITUDE
Therapy & Consultation

555 Poyntz Avenue • Suite 282 • Manhattan, KS 66502
Office: (785) 301-1542 • Fax: (785) 262-8393

PRACTICE POLICIES & INFORMED CONSENT

Welcome to Somatic Latitude, LLC. This agreement outlines important information about professional services and business policies. It is necessary to have a clear understanding about expectations and the therapeutic relationship. Feel free to discuss any of this with me and ask any questions. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox and providing your signature at the end of this document.

1. The client understands that counseling has benefits (such as improved problem-solving skills, emotional stability, relationships, and conflict resolution) and risks (such as increased awareness of distressing emotions, relationship changes, and recall of unpleasant events).

2. The client agrees to work with the therapist to identify treatment goals and follow up on referrals and/or recommendations (such as, application of skills, homework, other healthcare provider evaluation(s) or referral(s), etc.). The client understands that lack of participation and/or refusal will hinder the effectiveness of treatment and may result in termination and referrals.

3. The client understands that this office complies with standards set forth by HIPAA. No information will be shared without your written consent. However, there are exceptions, such as court orders, suspected abuse, neglect, and/or if you are a danger to yourself or others. While these situations are rare, the therapist will take action such as notifying the police, potential victim(s), seeking hospitalization for the client, and/or contacting family members or others who can provide protection. Therapists are mandated reported and must report any form of abuse to DCFS. The client understands that if an outside party requests protected health information, all adults involved in treatment are required to sign a Release of Information.

4. The client agrees to pay for services at the time of the session. If utilizing insurance, the client understands that the payment collected is based on the quote of benefits received from your insurance company. While I will file claims on your behalf, your participation may be necessary should problems arise. The client understands that any coverage issues are to be addressed by the client to the insurance company. The client does not hold Somatic Latitude, LLC liable for a misquote of benefits from the insurance company. Further, it is the responsibility of the client to ensure that all insurance policies are provided to Somatic Latitude, LLC, and failure to do so may result in errors in insurance payment, resulting in a recoupment by the insurance company and, therefore, a balance owed which will be the responsibly of the client. Additionally, if the client has not made a payment towards their account after three sessions, services may be suspended or terminated, and referrals may be offered.

5. The client understands that a diagnosis must be reported to insurance companies for a claim to be processed.

6. The client understands that a $50 fee will be charged directly to the client for any appointment cancelled/rescheduled with less than 24 hours' notice, and a $75 fee for any

appointment that a client no-shows (does not show up or cancel a scheduled appointment). In the event the client is more than fifteen minutes late for an appointment, the appointment will be considered missed and subject to the same cancellation fees described above. Clients are often scheduled on a reoccurring basis, which is discussed with the client during scheduling. Reoccurring appointments are still subject to cancellation, no-show, and missed appointment fees. These fees cannot be billed to insurance and will be the direct responsibility of the client.

7. The client understands that two or more no-shows, late cancellations, or missed appointments, termination will occur.

8. The client understands that if they have not been seen or scheduled an appointment for four consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, they are subject to termination.

9. The client understands that Somatic Latitude, LLC cannot be held responsible for providing services in the event of life-threatening/emergency situations. The client understands to contact 911 or go to their local emergency room.

10. The client agrees not to attend sessions while under the influence of alcohol or other drugs/substances. If the therapist believes the client is under the influence of alcohol or drugs, the session will be terminated and coordination of a ride home will be assisted, even if that requires contacting an emergency contact.

11. The client understands that emails and text messaging are not 100% confidential and they will do so at their own risk. SimplePractice is an electronic health record which offers a secure, encrypted client portal. By establishing such, the client agrees to provide accurate and complete information. Letters, notices, statements/invoices and other confidential information will be delivered via SimplePractice. During intake, the client will also receive an invite to Spruce Health, which offers a secure, encrypted messaging platform to securely message therapist in lieu of phone calls. Messaging outside of Spruce Health may result in a reply via Spruce Health, depending on the content of such communication.

The client understands that they are deemed to have agreed to receive schedule and form/notice reminders, statements/invoices and letters or other formal communication from SimplePractice (schedule reminders can be delivered by SimplePractice via text and/or email) and office closures (or similar notifications) from Spruce Health via text message unless they opt out. Likewise, the client understands that text messaging rates may apply based on their phone plan. Both SimplePractice and Spruce are free of charge to download and operate. The client understands that should they choose not to participate in SimplePractice and/or Spruce, email, phone calls, and postal mail will be used.

12. The client understands that the therapist does not accept social media friend requests or follow client accounts.

13. The client agrees to pay $35 on each returned check in addition to the original amount of said check(s).

14. The client understands that the therapist will not become involved in any custody, visitation, or legal disputes without the therapist's agreement and prepayment made by the

client. Such services will be billed at three times the hourly rate, plus mileage, and require a four-hour minimum payment.

15. The client understands that in divorce situations, payment will only be collected from the parent who initiated services. Divided/Split billing is not offered. These types of arrangements are to be facilitated between the parents. It is also expected that the individual representing a minor has privileges to consent to medical care. While a copy of the divorce decree may be requested, Somatic Latitude, LLC will not be held liable for misrepresentations by a parent/guardian or caregiver.

16. The client acknowledges that they have read the Kansas Notice of Privacy Practices (HIPAA).

17. The client understands that any unscheduled calls between the client and therapist exceeding 10 minutes will result in a fee added to the client's account based on the time of the call. Such fees may also be incurred in the event of excessive messaging between sessions. The client understands this cannot be billed to insurance.

18. The client understands that preparation of a report may result in a fee added to the client's account. If a request for medical records by the client or third party is made, there will be a $25 charge for any request exceeding one.

19. The client understands that the therapist reserves the right to make final decisions about exceptions to these policies; provided, they are legally appropriate.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Name: _____

Client Signature: _____ Date: _____