



Desert Counseling & Recovery Services PLLC

Office Policies and Statement of Informed Consent

This document (the Agreement) contains important information about the professional services and business policies of Desert Counseling & Recovery Services PLLC. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that Desert Counseling & Recovery Services provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of Personal Health Information (PHI) for treatment, payment and health care operations. The law requires that Desert Counseling & Recovery Services obtain your signature acknowledging that you have been provided this information prior to the end of your session. If you have questions about this document, please feel free to ask.

When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on Desert Counseling & Recovery Services unless we have taken action in reliance on it (for example, if there are obligations imposed on Desert Counseling & Recovery Services by your health insurer in order to process or substantiate claims made under your policy or if you have not satisfied any financial obligations you have incurred.)

Objectives of Counseling:

Often times we become encumbered with thoughts, behaviors, habits, and perceptions that affect our ability to be authentic with ourselves and others. When we hide ourselves or repress parts of ourselves in an effort to protect ourselves from feeling pain, we also diminish our ability to handle the challenges of life and connect with others. The goal of counseling is to identify with the underlying causes that lead to destructive behaviors and conflicts that we face. This is done through:

- Healing from the emotional, physical, and spiritual wounds that have been inflicted on you throughout your life.
- Shedding the layers of personal deception that prevent you from being fully aware of yourself.
- Owning the parts of your life that you have the ability to change and taking the bold steps to move forward towards desired outcomes.
- Taking responsibility for your own thoughts, feelings, and perceptions and allowing yourself the ability to change them into healthy, productive thoughts and feelings that will lead you to better future experiences.

It is important to note that only you have the ability to work through your issues. Counseling provides a safe environment in which you can face the issues that hamper your progress, but you still remain responsible for the desired outcomes. Your therapist can guide, direct, and inspire, but for the work to be done, you will have to be responsible to do it. You may be given activities to accomplish between therapy sessions. Whether you do them or not will affect the outcomes you are trying to achieve. Your ability to move forward often rests heavily on what you do in between sessions.

Risks of Therapy:

There are risks in starting therapy. Foremost is facing your fears. This can be tremendously daunting and evoke a range of strong emotions. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Your therapist will not force you to go or do anything for which you are not ready. You may be challenged to complete stretching assignments that take you out of your comfort zone; however, you will never be forced to do anything that you are not willing to do. Please keep your therapist apprised as to what feelings are evoked during and after sessions as well as honestly helping the therapist understand what you feel and don't feel comfortable doing.

Client-Therapist Boundaries:

In order to help foster a safe, professional and therapeutic environment, the Arizona Board of Behavioral Health Examiners has set forth ethical rules regarding the counseling profession. According to these guidelines, it is an ethical violation for your therapist to accept or receive gifts or to establish any relationship with a client, besides that of client/therapist, even after you have completed your therapy. Once you have entered into a client/therapist relationship, the relationship will be limited to these roles even after you have completed your treatment. For further clarification, please discuss with your therapist.

Client's Initials _____

Scope of Practice:

The staff at Desert Counseling & Recovery Services is not on-call, nor do they have an emergency staff for after-hours treatment. **If you encounter a life-threatening emergency CALL 911 immediately.** Your therapist is not available after normal business hours. If you encounter a non-life threatening emergency, contact Desert Counseling & Recovery Services during normal business hours and discuss the possibility of scheduling an emergency session. If you are unable to reach your therapist, you may call your primary care physician. Certain conditions and diagnosis are also not within the scope of our therapists' expertise (e.g., severe mental illness). Given the nature and scope of our practice, we reserve the right not to treat persons with certain diagnoses or treatment histories; however these individuals can be referred to professionals that can better meet identified treatment needs. These include:

- Any Severe Mental Illness: (including but not limited to Schizophrenia, and Dissociative Identity Disorder)*
- . Anti-Social, Paranoid, Schizotypal or Dependent Personality Disorders
- . Impulse Control Disorders (Intermittent Explosive Disorder, Kleptomania, Pyromania, Trichotillomania)

There may be other reasons for which your therapist may find it in your best interest to refer you to more specialized treatment. These include but are not limited to:

- . Failure to disclose History of Prior Hospitalization or in-patient treatment for mental health issues (e.g., suicide attempt, eating disorder, substance abuse).
- . Failure to disclose ongoing substance abuse or current Involvement with any illegal activity

By signing this agreement, you are stating that you have never been diagnosed with any of the disorders listed as being outside the scope of practice as described above and that you have fully disclosed previous hospitalizations or participation in-patient treatment.

Treatment of Minors:

Desert Counseling & Recovery Services will provide counseling to minors (individuals under the age of 18, who are not emancipated). If a parent/legal guardian is bringing the child in for services, the **written consent of both parents** and/or legal guardians is required except as otherwise determined by law. Additional documentation of guardianship might need to be provided in certain circumstances, such as divorce, before treatment can begin. For children younger than 12, the therapist will need to evaluate the situation prior to accepting the child as a client.

Patients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in therapy is often crucial to successful progress, particularly with teenagers, it is sometimes our policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, we will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

Record Keeping:

It is required that a clinical record be maintained that includes assessments, treatment plans, dates and times of therapy sessions, and notes describing your progress. Records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section below. Clinical records are maintained in a secured manner that complies with HIPAA regulations. You may receive a copy of your records if you make a formal written request and pay a \$50 retrieval fee. Please be advised that it may take up to 30-days to receive your records from the day your request is obtained. If your therapist determines it would not clinically be in the client's best interest to receive the complete records, a summary of the notes will be provided instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in the presence of your psychotherapist, or have them forwarded to another mental health professional so you can discuss the contents.

Client's Initials _____

Confidentiality:

The basic rule of therapy is that what is said in a session – stays in a session. **None of the staff or therapists at Desert Counseling & Recovery Services will share any information about what takes place at Desert Counseling & Recovery Services with any individual without your express written authorization or as required by law. Instances in which disclosure would be required include, but not limited to:**

- Suspected abuse or neglect of a child.
 - *This is a state mandated requirement.*
 - Sexual activity between a minor and any person age 18 years or older. *This is a state mandated requirement.*
- Suicidal or homicidal ideation with the intention to act on this ideation.
 - *(In the event that you disclose information that you are a danger to yourself or others and you are unwilling to voluntarily admit yourself to inpatient care (hospital or other treatment facility), State Law requires that a psychiatric facility or hospital be contacted to file the appropriate papers for an involuntary admission for treatment. This is to ensure safety for yourself and others and ensure you receive appropriate medical treatment. State law also requires that potential victims and the police be notified if you disclose intentions to hurt another person(s).)*
- A Court subpoena ordering the release information as part of a legal involvement.
- Billing insurance companies (for example, filing a claim, responding to insurance audits, or appealing denials, etc).
 - While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your written, signed Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal.
 - You may examine and/or receive a copy of your psychotherapy notes unless we determine that such access is clinically contraindicated.
- In natural disasters whereby protected records may become exposed.
- In the event that you would like your therapist to speak with other health professionals or other identified individuals, you will be required to complete a Release of Information form. Staff and therapists at Desert Counseling & Recovery Services **will not share information to any individual** (except as outlined above) **without written consent**.

Patient Rights:

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record (must be made in writing); requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting 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 our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. Your therapist will be happy to discuss any of these rights with you.

Appointments:

Appointments are usually scheduled for 50 minutes. If you require longer sessions, please discuss this with your therapist. You and your therapist will also discuss how often it is recommended that you be seen. Please remember that you may discontinue treatment at any time. Phone sessions are billed at the same rate as face-to-face sessions.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, you should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

Client's Initials _____

Fees:

Payment is due at the time of service. The fee for individual and/or family counseling services is **\$150.00 for a 50-minute session**. Longer sessions will be billed based on the duration of the session (e.g., 1 ½ hours = \$225). Fees may be paid with cash, check, or credit card.

If you have out-of-network benefits, your insurance may reimburse you for a portion of this fee. We will provide you with a statement with which you may bill your own insurance for reimbursement.

Other Fees:

- Court reports \$125.00
- Court appearances \$250.00 per hour for preparation, professional time and court interactions.
- Client is responsible for all attorney fees incurred by Desert Counseling.

Cancellations and Missed Appointments:

We require 24 hours' notice of a cancellation of an appointment. Failure to provide such notice, regardless of the reason, will result in you being billed \$50.00. Insurance generally will not reimburse you for missed or late-cancelled appoints. Please be aware that you **will be billed \$50.00 for any cancellations made less than 24 hours prior to your scheduled appointment**. In addition, **your therapist will be unable to continue seeing you if you no-show for two consecutive sessions**. Your file will be closed and a letter notifying you of this will be sent to the address listed on your intake paperwork.

Unpaid Balances:

All payments are due at the time that services are provided. In the unlikely event that you generate a balance, it is important for you to understand that your therapist will be unable to continue seeing you for scheduled sessions once you accrue an overdue balance of \$200 or more.

Collection Agreement:

In the event that you fail to pay for the services provided by this office in a timely manner, your account may be sent for collection. There will be a collections fee added to the bill equal to 40% of the balance owing at the time the account is placed for collection. You will also be billed for all attorneys' fees and court costs incurred necessary to collect this balance.

Consent for Treatment:

By signing below, you are stating that:

- 1) You have read and understood this 4 page policy statement. Including:
 - The 24-hour cancellation policy, which includes a \$50.00 fee for appointments that are missed or cancelled without giving 24 hour notice.
 - Two consecutive no-show appointments will result in being terminated from our services.
 - All payments are due at the time that service is provided.
 - Court Fees and client responsibility to cover court expenses at \$250 per hour.
- 2) You have had your questions answered to your satisfaction.

I accept, understand, and agree to abide by the contents and terms of this agreement. Further, I consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time. In the event that I fail to pay for the services provided by this office, and the account is placed for collection, I understand and agree that an additional amount equal to 40% of the balance owing at the time the account is placed for collection will be added to the current balance owing. I further agree to pay all attorneys' fees and court cost, necessary to collect this balance.

Client's Printed Name: _____

Client's Signature: _____ **Date:** _____

(Or GUARDIAN if client is a minor)

Therapist's Signature: _____ **Date:** _____

Client's Initials _____