Rick Hupp, M.S., LMFT, SEP

Licensed Marriage and Family Therapist, MFC#78320

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AGREEMENT FOR SERVICE / INFORMED CONSENT

Introduction

This Agreement is intended to provide [first & last name(s)] 1st client ➲_____, 2nd client if a couple ➲_____ (herein "Client(s)") with important information regarding the practices, policies and procedures of Rick Hupp (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Client. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Risks and Benefits of Therapy

Psychotherapy is a process in which Therapist and Client discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Client can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Client may be experiencing. Psychotherapy is a joint effort between Client and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to Client, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of Client, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Client's perceptions and assumptions, and offer different perspectives. The issues presented by Client may result in unintended outcomes, including changes in personal relationships. Client should be aware that any decision on the status of his/her personal relationships is the responsibility of Client.

During the therapeutic process, many Clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Client should address any concerns he/she has regarding his/her progress in therapy with Therapist.

Professional Consultation

Professional consultation is an integral component of maintaining a high-quality psychotherapy practice. Therapist may consult with trusted professional resources to enrich treatment planning, gather resources, and support effective interventions. On occasion, select supportive tools, which may involve technologies powered by artificial intelligence, may assist in generating treatment insights, summaries, or materials to enhance the therapeutic process. All consultations are conducted with strict adherence to confidentiality; no personally identifying information regarding Client will be shared.

Court-related Services

Therapist is not a forensic therapist and reserves the right not to participate in legal proceedings, nor offer therapist's opinion to any court of law in the form of a letter, consultation, appearance or telephone testimony for the court. If asked to do so, therapist will consider, on a case-by-case basis, whether therapist can adequately participate in court-related services. Therapist will not voluntarily participate in any litigation, or custody dispute in which Client and another individual, or entity, are parties. Therapist has a policy of not communicating with Client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Client's legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Client, Client agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made himself available for such an appearance at Therapist's usual hourly rate.

Records and Record Keeping
Therapist may take notes during session, and will also produce other notes and records regarding Client's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his normal record keeping process at the request of any Client. Should Client request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Client with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Therapist will maintain Client's records for ten years following termination of therapy. However, after ten years, Client's records will be destroyed in a manner that preserves Client's confidentiality.

Confidentiality
The information disclosed by Client is generally confidential and will not be released to any third party without written authorization from Client, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a Client makes a serious threat of violence towards a reasonably identifiable victim, or when a Client is dangerous to him/herself or the person or property of another. When more than one family member is being seen in therapy (i.e. in couple or family sessions) the therapist views the family as a whole as the client. Therefore, releases of information for family sessions require the written approval of each consenting member of the family who was present at any time during the treatment. (This does not apply to a 'guest' whom the client invites who is not the focus of treatment.) Additionally, the family must agree that the therapist will not collude with individual members to keep individual confidences that are harmful or destructive to other family members in treatment. Where conflicting family members' goals exist, the objective of therapy is for everyone's goals to be addressed in a manner that will preserve the integrity of the family as a whole. Differences between each family member's goals will be discussed during therapy. **Please initial here: _____/_____**

Psychotherapist-Client Privilege
The information disclosed by Client, as well as any records created, is subject to the psychotherapist-Client privilege. The psychotherapist-Client privilege results from the special relationship between Therapist and Client in the eyes of the law. It is akin to the attorney-client privilege or the doctor-Client privilege. Typically, the Client is the holder of the psychotherapist-Client privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-Client privilege on Client's behalf until instructed, in writing, to do otherwise by Client or Client's representative. Client should be aware that he/she might be waiving the psychotherapist-Client privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Client should address any concerns he/she might have regarding the psychotherapist-Client privilege with his/her attorney.

Fee and Fee Arrangements
Unless agreed to prior, the usual and customary fee for service is $230 per 50-minute session. Sessions longer than 50-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Client will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payors, or by agreement with Therapist.

From time-to-time, Therapist may engage in telephone contact with Client for purposes other than scheduling sessions. Client is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at Client's request and with Client's advance written authorization. Client is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes.

Clients are expected to pay for services at the time services are rendered. Therapist accepts IVY Pay, Zelle, PayPal, cash, check & credit card.

Insurance
Client is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payor. Client is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles. Therapist is not a contracted provider with any insurance company, managed care organization. Should Client choose to use his/her insurance, Therapist will provide Client with a accounting statement, which Client can submit to the third-party of his/her choice to seek reimbursement of fees already paid. In the event an insurance company or managed care organization seeks additional information to process a claim made by client, therapist reserves the right to refuse or limit the release of information requested by those third parties. On a case-by-case basis, therapist may respond to such requests at therapist's discretion and will seek approval from client prior to doing so. Client agrees to pay same clinical fee for service rate listed above to therapist for administrative time used to respond to, interact with, and transmit requested information to insurance company and/or managed care provider.

Cancellation Policy

Client is responsible for payment of the agreed upon fee for any missed session(s). Client is also responsible for payment of the agreed upon fee for any session(s) for which Client failed to give Therapist at least 24 hours' notice of cancellation. Cancellation can be initiated via link found in original email confirmation or should be left on Therapist's **voice mail or via text at (818) 822-6644**.

Therapist Availability

Therapist's uses a confidential voice mail system that allows Client to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

Termination of Therapy

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Client needs are outside of Therapist's scope of competence or practice, or Client is not making adequate progress in therapy. Client has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Client participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Client.

Acknowledgement

By signing below, Client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Client has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Client's satisfaction. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Client agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____ ___/___/_____
Client Name (Please Print) Birthdate

_____
Street Address

_____
City, State Zip

(_____)_____
Best phone to reach you

OK to leave therapy relevant VOICE messages? [Yes] [No]
OK to text therapy relevant messages? [Yes] [No]
OK to discuss therapy via E-Mail? [Yes] [No]

_____@_____
Your Direct Private Email

_____ _____
Signature of Client Date

_____ ___/___/_____
Client Name (Please Print) Birthdate

_____
Street Address

_____
City, State Zip

(_____)_____
Best phone to reach you

OK to leave therapy relevant VOICE messages? [Yes] [No]
OK to text therapy relevant messages? [Yes] [No]
OK to discuss therapy via E-Mail? [Yes] [No]

_____@_____
Your Direct Private Email

_____ _____
Signature of Client Date

How did you find me? _____

Emergency Contact :_____

Best Phone:_____

Relation to you :_____

Emergency Contact :_____

Best Phone:_____

Relation to you :_____

TELEMEDICINE INFORMED CONSENT FORM

I [your name(s)]_____/_____ hereby consent to engaging in telemedicine with Rick Hupp as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California.

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. In addition, 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.

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

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

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

_____		_____	
Client Name (Please Print)		Client Name (Please Print)	
_____	_____	_____	_____
Signature of Client	Date	Signature of Client	Date

_____	_____
Therapist (Rick Hupp)	Date

Permission for Digital Recording of Therapy Sessions

As a primary tool in therapy, and in order to augment your therapy work, I use digital audio and video feedback as part of therapy sessions. This means that I may ask to record you during specific dialogues or exercises or during entire sessions. Occasionally, we will play back these sessions to help you see patterns of behavior to help you process. Viewing them in sessions allows us to "stop action" and process how you might approach things in a more productive way. It also allows you to witness your progress as your relationship with yourself and others becomes more satisfying.

In addition to in-session use, on rare occasions, I may wish to use the recordings to receive consultation from my supervisor or colleagues. Occasionally, select resources, which may involve supportive tools powered by artificial intelligence, may assist in generating notes, summaries, or other materials to enhance your therapeutic progress. This may occur for purposes of peer review, education, and quality assurance, with the goal of making therapy more effective. During this process, your name and identifying information will be kept confidential. Additionally, all matters discussed in consultations will remain completely confidential. The recordings will be used for no other purpose without your written permission and will be deleted when no longer needed for these purposes. Often, the recordings are deleted at the conclusion of each session if not clinically significant.

These recordings are my property and will remain solely in my possession during the course of your therapy. Should you wish to review these recordings for any reason, we can arrange a session to do so. The recordings are digitally encrypted and password-protected on secure media at all times until deleted.

Client(s)' Agreement:
I understand and accept the conditions of this statement and give my permission to have my therapy sessions recorded. I understand I may revoke this permission in writing at any time, but until I do so, it shall remain in full force and effect.

_____		_____	
Client Name (Please Print)		Client Name (Please Print)	
_____	_____	_____	_____
Signature of Client	Date	Signature of Client	Date

_____	_____
Therapist (Rick Hupp)	Date

CONFIDENCE POLICY (FOR COUPLES CLIENTS)

Sometimes, in the course of couples counseling, I may choose to see one or both of you individually in order to advance your progress together. In some cases, an individual might share with me a secret they do not want shared with their partner. If I am to treat you in the most effective way possible, I need you both to be transparent with me, even in the ways you are not willing or ready to be transparent with each other. If you lie or omit information from me, I will not be able to fully assist the secure functioning of your relationship and the therapy may be less effective.

It is for this reason you may opt for this confidence policy. This means if one or both of you tells me a secret, I will hold that information in confidence as privileged information from the other partner. Both parties must agree to allow me to intentionally hold that in confidence if their partner has shared with me in confidence. If you have a secret, please be very explicit and clear with me about what you want shared or not shared. Something like, "My husband knows I have a job at the bank, but he does not know I was demoted, and I do not want him to know. Please do not share my demotion with him." **Please do not assume I have heard your request for confidentiality until I repeat your request explicitly**; something like, "I understand your husband knows about your job at the bank, but you would like me to keep your demotion a secret from him. I will hold this information in confidence."

My choice to hold confidence does not in any way mean I favor one partner over the other or have any special alliance with one partner over the other. I am in favor of transparency in a securely functioning relationship; however, I will hold confidence and work with you individually in service of moving towards secure function through eventual transparency in your relationship, and exploring what makes it difficult to share private information with your partner.

•I have read this **Confidence Policy**, and I agree that our couple therapist Rick Hupp, LMFT may hold privileged information (secrets) in order to maintain the confidentiality of my partner.
•I understand that this does not mean my therapist has an unfair alliance with my partner.
•I understand that if he holds a privileged information from me, he is still working in service of me, my partner, and our relationship.
•I agree to tell Rick Hupp, LMFT the whole truth and be clear and explicit with him if I do not want information shared with my partner.

_____ _____
Signature Date

_____
Printed Name

_____ _____
Signature Date

_____
Printed Name

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at (818) 822-6644 or www.responsiverelating.com

If you have any questions about my Notice of Privacy Practices, please contact me at:
Rick Hupp, 22221 Kittridge Street, Woodland Hills, CA 91303 (818) 822-6644 rick@hupp.com

I acknowledge receipt of the Notice of Privacy Practices of Rick Hupp.

_____		_____	
Client Name (Please Print)		Client Name (Please Print)	
_____	_____	_____	_____
Signature of Client	Date	Signature of Client	Date

You did it! Thank you!