Welcome to the Center for ADHD, Behavior Change, and Social Success! This information is provided to facilitate the best treatment for all clients in this office. Please read all pages in their entirety before signing that you understand the policies. Our primary concern is that you receive quality, respectful, and confidential treatment here.

Therapist

Audra Boxma LMHC, LCPC, NCC, CCMHC, CTMH, ADHD-CCSP is a Licensed Mental Health Counselor (LMHC) and LMHC Supervisor in the state of Florida. Also, she is licensed in Illinois as a Clinical Professional Counselor (LCPC). In addition, she holds 2 National Certifications: Nationally Certified Counselor (NCC) and a Certified Clinical Mental Health Counselor (CCMHC). She is a **Certified Clinical Telemental Health provider (CTMH), and an ADHD Certified Clinical Services Provider (ADHD-CCSP).** "Miss Audra" graduated

with her **Bachelors degree** in mental health from the University of Illinois at Chicago. She earned her **Masters degree** in clinical psychology from Roosevelt University, **graduating with a 4.0.** She has been working with children and families for over 20 years.

Therapy

Therapy is the Greek word for change. We understand it is difficult to seek help from a mental health professional. It is important that you understand that this is a safe place. This is a place of learning, not a place of judgment. Our focus is how to better the situation, not to determine who is to blame for the situation. We want you to feel comfortable here and comfortable with your therapist.

We hope that with therapy you will be better able to understand your situation and feelings and move toward an improved skill set and solutions. The therapist, using her knowledge of human development and behavior will make observations about situations, as well as suggestions for new ways to approach them. **It will be important for you to explore your own feelings and thoughts and try new approaches in order for change to occur. Practice is the vehicle for change.** You may bring other family members to a therapy session if you feel it would be helpful or if this is recommended by your therapist. The number of sessions will be based on your goals for therapy and the duration and the intensity of the behaviors. Your therapist will discuss this with you during your evaluation. The mode of therapy is primarily cognitive, behavioral, and brief, solution-focused therapy. If you are engaged in a legal dispute regarding

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your child such as a custody or divorce situation, it is imperative that you inform Ms. Boxma during the first session.

There may be risks associated with therapy. A risk you may encounter is that you may learn things about yourself or your child that you don't like. Often growth cannot occur until you experience and confront issues that may cause you to feel sadness, sorrow, anxiety, or pain. **The success of your work with your therapist depends on the quality of the effort put forth in therapy.**

You will be learning new ways to change the system, to get "unstuck", to break old patterns of interaction, and that may be scary at first. Some children exhibit poor behaviors with more frequency or intensity at first as they resist change. This process is called "extinction burst".

They are also looking to see if you will give up or give in, or if you plan to follow through. You always have the right to terminate therapy at any time, however, it is significantly detrimental to terminate therapy when the initial resistant behaviors are present. That is the time when the change will begin. Impeding or cutting off the process at that time will not evoke change. Cessation will serve to reinforce poor behaviors. The initial resistance should not last for an extended time, if you are consistent. Hence, it is important to make a commitment with your family if you choose to continue therapy after your evaluation. As you work through the issues, rather than around them, you can put them in the past and emerge a happier, healthier family.

Office Hours

Office hours are by appointment- 11am to 7 p.m. Monday through Thursday. You may reach the office by calling (239) 963-7274. The voicemail is confidential, and we strive to return your call within 48 hours.

Appointments

Appointments are necessary to provide the highest level of care. Initial appointments generally last 1-1.5 hours. Individual and family therapy lasts 45 minutes. Your appointment time slot is for 45 minutes. If you arrive 10 minutes late, you will still have 35 minutes remaining. Group therapy is 1.5 hours. Promptness is encouraged in order to help us provide efficient care for all clients. **We understand that your time is valuable.** Every effort will be taken by your therapist to be on time and ready for your session to begin. Please try to understand that occasionally your therapist may be running late because another family earlier in the day was in crisis. It is impossible to plan for crisis and the therapist can not send a family away because the timer has rung. Please be patient and recognize that if you were in crisis you would not want to be sent away when the 45 minutes have expired. However, we will strive to not ever have you wait longer than 15 minutes.

Appointment Cancellations

Please notify the office in advance if you are unable to keep your appointment. **Failure to notify the office 24 business hours prior to the scheduled time will result in a cancellation fee of your session rate.** If you have a credit card on file, you will be charged on the card for the cancellation. Without 24 hours notice, it is not possible for the therapist to reschedule your timeslot. Please record your appointment times, as you will not receive a reminder call or email.

Emergencies/Crisis

Your therapist is not available for crisis work after hours or on the weekends. During this time, **in the event of an emergency,** you may call 911. **An example of a psychiatric emergency is if your child states he or she wants to harm himself/herself or others, runs away, or has been abused, and you don't know what to do.** If you have an emergent situation, please call 911, the mobile crisis unit (844) 395-4432 or the David Lawrence Center after hours. If you speak to the therapist during office hours **you will be charged for crisis services rendered, including phone calls, at your regular rate.**

Payments

Full payment must be paid on the date services are rendered. If you have a credit card on file, your card may be used for your future appointments upon your request. **Any accounts past due 45 days will be forwarded to a collection agency.** Please inquire or make arrangements to pay your balance before your account becomes delinquent. If your check is returned due to insufficient funds, you will be charged a $35.00 fee in addition to the amount that is due.

Ongoing Communication

All mailed correspondences will be sent in an envelope with the center's name. Please advise the therapist if your address has changed. Signing the form indicates your consent for the therapist to communicate with you by mail, email, or by phone from the information you have provided on the demographics packet. Also, understand there are confidentiality risks if you send an email requesting a response with personal information, as the response will not be encrypted.

Fees

Initial Interview	**$325.00/ +$125 extra child**	1.5- 2.0 hours
Extended therapy	**$25.00**	46-60 min session
Cancellation Fee/ No show	**Your session rate**	**24 hrs. notice required**

***Therapy- individual or family $175.00 per 45 minute session**
If you are a police officer, military, or are a teacher, you qualify for the discounted rate of $150 per 45 minutes session. These listed are cash rates: cash, Zelle, or check. Credit card rates are $10 additional or 5%.
If a session is extended (46 mins- 60 mins), add $25.00 to your rate. If a session is 70-75 minutes, the rate is 1.5. If a session is 90 minutes, the rate is doubled.

The credit card statement will show a charge from "ABCSS".
Center for ADHD, Behavior Change, and Social Success.

Crisis Phone Consultations	Prorated at session rate	Calls >5 minutes
Group Therapy	$125.00 per session	1.5 hours
504/IEP/School meeting	$175.00 (per 45 minutes). Travel time is added at the same rate as your clinician can not see another client during that time.	

Divorce planning	$300.00 per 45 mins
Returned or NSF checks	$35.00 per check or credit card disputed
Subpoena/Court Testimony	$600 per 45 mins/ $600.00 minimum

Preparation/Phone Calls (Travel costs and travel time **additional** at same rate)

***If treatment is terminated and you later decide to resume therapy, you will subject to paying the new rate. You may keep your file open and retain your current rate.**
Please note insurance companies generally don't reimburse for extensions.

However, all companies are different. **Please tell the therapist if you do not want to exceed 45-50 minutes in the beginning of each session.** Although it is the goal of the undersigned therapist to protect the confidentiality of your records, **there may be times when disclosure of our records or testimony will be compelled by law**. Confidentiality and exceptions begin on page 7. In the event disclosure of your records or testimony is required by law, you **will be responsible for and shall pay the cost involved in producing the records and the therapist's full rate for the time involved in preparing for and giving testimony.** Such payments are to be made prior to the time services are rendered by the therapist. You have the right to request a copy of your records for a reasonable fee. Allow 30 days for record requests to be fulfilled. The charge for a medical record is $35.00, or greater if the file is extensive.

Insurance

The providers at the center are not in network providers for any insurance companies. However, we are considered out of network for many insurance companies.
If you have out of network benefits, you may file a claim to your insurance company for reimbursement. **You are responsible to pay the full amount at the time services are rendered. Your therapist will provide you with a formal invoice of all sessions each week to use to file your claim.** Be aware, that most insurance companies will request detailed information regarding the sessions, such as diagnosis, treatment goals, progress, and/or other personal information. By signing this form, if you submit a claim, you are authorizing the therapist to provide the records/information requested in verbal and/or written form.

If you do plan to file, please call the insurance company and identify what codes are covered BEFORE THERAPY BEGINS so you know what is covered.
(90834=individual therapy, 90847=family therapy, 90846=family without patient, 90853=group therapy). If you don't call when therapy starts, you may find the insurance company may deny your claims in the future if the correct code has not been reported. We can not go back and change the code, as that is considered insurance fraud. The code is reported based on the manner in which we meet-either individually, family therapy, etc. **Please call in advance to make sure our sessions will be covered, if you plan to file.**
If you **chose not** to involve your insurance company be advised:

- **No** entity has access to our files or records (your most personal information). Thus, the only people who know you are here are you and your therapist- period.
- Your confidential information will **not** be shared with your employer, insurance company, or any unknown parties associated with the insurance companies.
- Your child's treatment will **not** be dictated by an insurance reviewer who has never met your child. Length of treatment will be suggested by the therapist and decided by you or legal guardians.
- The length of your child's treatment and the number of sessions will **not**
- be determined by an insurance company, it will be based on need. The providers at the Center will have more time to work with families, since they are **not** spending an abundance of time with insurance companies.
- Your family and your child will be provided with the best treatment **tailored** specifically for your needs, as there will not be any constraints by managed care.
- A sliding scale fee is available for individual and family therapy session to provide all members of the community with an opportunity for personal growth.

Complaints/ Concerns

The Center encourages you to address any complaints or dissatisfaction directly with your therapist as soon as they arise. Your concerns may be an important part of your child's therapy. Your therapist also has a supervisor you can speak with to discuss your concerns. Also, you may notify the Florida Department of Health Consumer Services Unit, Tallahassee, FL 32399-3260 at (850) 245-4339.

Other general information

- **Center therapists may confer with other licensed professionals for supervision.** Your name or other identifying information will not be provided, ensuring your confidentiality at all times. All supervisors are licensed providers and are bound by the same scope and limitations of confidentiality as your therapist.

- The type of therapy utilized is cognitive, behavioral, reality, brief, and solution focused. Other treatment methods available at other facilities are medication, herbal remedies, chiropractic, acupuncture, diet, allergy shots, play therapy, or no treatment at all.
- In the event that the undersigned therapist becomes incapacitated or dies, it will be necessary for another therapist to take possession of files and records. All files will be sent to the state licensing board- the Florida Department of Health. Signing this form indicates that you consent to the Health Depratment to take possession of the files and records. They will provide you with copies of your records at your request or send them to a therapist of your choice.
- Because the therapeutic relationship is not a personal relationship, no bartering, gifts, or trading is allowed. Your therapist cares about you, but will not become a personal friend, as that may damage the therapeutic relationship. Licensing guidelines clearly state that social relationships are not acceptable. In the event that you see your therapist in a public place, you have the option to acknowledge or ignore her. Due to confidentiality, your therapist will not acknowledge that she knows you unless you initiate conversation or acknowledgment.

Confidentiality

Discussions between a therapist and a client are confidential. Confidentiality is the act of holding anything said or written during your therapy session as private. It ensures that the information is a secret between you and your therapist. No information will be released without the client and/or legal guardian's written consent unless mandated by law or identified as an exception below. The fact that you are here is confidential. The fact that your family or your child is receiving treatment here is confidential. It is of utmost importance at the Center. Thus, if your therapist is returning your call, and you are not available, it is possible that she may not identify herself as a therapist from the Center. She may just provide her name yet will not discuss what the call is regarding. All licensed therapists are responsible for maintaining confidentiality as outlined in the ethical guidelines of practice as established by the Florida Department of Health. Adolescents have a right to this confidentiality as well.
Please read the next section to clearly understand the exceptions to confidentiality, these include but are not limited to the following situations:

Limits on Patient Confidentiality

We will disclose confidential information if any of the following exist:

1. You are a danger to yourself or someone else.
2. You become homicidal or suicidal, in which case the therapist is authorized to call anyone who may be in a position to prevent harm to yourself or others.
3. You are engaging in dangerous behaviors.

4. Physical abuse is suspected or reported.
5. Sexual abuse is suspected or reported.
6. You seek treatment to avoid detection or apprehension or enable anyone to commit a crime.
7. You are under the age of 16 years and are a victim of a crime.
8. To decide an issue concerning a deed or conveyance, will or other writing executed by you.
9. You file suit against your therapist for breach of duty or your therapist files suit against you.
10. You are involved in a criminal prosecution.
11. You have filed suit against anyone and have claimed mental or emotional damages as a part of the suit.
12. You file a complaint with the licensing board.
13. There are fee disputes between the therapist and the client (collections)
14. The court orders release or review of the records.
15. Situations which, in the therapist's judgment, it is necessary to warn or disclose for safety.
16. You have consented to disclosure by signing a release of information form.
17. If you are under the age of 18, your parent and/or legal guardian is entitled to all information about your treatment such as your goals, your progress, the focus of sessions, and treatment recommendations etc. If you do not want specific details disclosed to your parent, your parent must sign a confidentiality waiver form.
18. AIDS/HIV infection and possible transmission.
19. If you file a claim, your insurance company reimbursing you for services has the right to review all records (including diagnosis).

If you have any questions about these limitations, please discuss them with the therapist before signing this form. By signing this form you are giving your consent to the undersigned therapist to share confidential information to any persons mandated by law and the managed care company responsible for providing and paying for mental health services, if you file a claim. You are releasing and hold harmless the undersigned therapist from any departure from your right to confidentiality that may result. By signing this form you assert that you understand these policies and agree to abide by them. You voluntarily agree to receive mental health services and authorize the undersigned therapist to provide such care, treatment, or services, to your family and your child as are considered necessary and advisable. You understand that you will participate in the planning of your (child's) care and that you may stop such care, treatment, or services at any time. Please sign to acknowledge that you have read all of the 7 pages preceding and that ample opportunity has been offered to you to ask questions and seek clarification of anything unclear.

I, as the CLIENT or legal guardian, authorize Audra Boxma LMHC, LCPC, NCC, CCMHC, CTMH, ADHD-CCSP to treat me (and my child ongoing). I understand all of the office policies, modes of treatment, risks, and goals and agree to abide by them. I have had ample opportunity to ask questions.

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Parent/ Legal Guardian/ Client **Date**

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Witness/ Undersigned Therapist **Date**

I am a public servant, military, or a teacher and qualify for the discounted rate.

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Parent/ Legal Guardian/ Client **Date**

I, as the CLIENT or legal guardian, authorize Audra Boxma LMHC, LCPC, NCC, CCMHC, CTMH, ADHD-CCSP to treat me (and my child ongoing). I understand all of the office policies, modes of treatment, risks, and goals and agree to abide by them. I have had ample opportunity to ask questions.

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Parent/ Legal Guardian/ Client **Date**

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Witness/ Undersigned Therapist **Date**

Authorization for Payment

I am deeply committed to the clinical care provided to you and your family.
If you chose to put a credit card on file, we can use all of our therapy time attending to your solutions. If you instruct me to "Put the session on the card on file", no time will be used to process payment during the session. MasterCard, Visa, or Discover are accepted.
To process credit cards, I use a credit merchant called Therapy Partner, which is highly secure. It has a SSL High-Grade Encryption certificate verified by Verisign. Its servers are at a Tier III data center with provides strict physical security. It also offers a state of the art firewall and architecture to prevent unauthorized access.
Please note that 24 hours notice is required for cancellations or there is a $100.00 cancellation fee. Your time slot can not be rescheduled and used for another family without advance notice.
You will receive an invoice that you can use to send to your insurance company for reimbursement. If you would like to put a card on file, please complete the following:
CLIENT Name: __________________________ Date of Birth _______________

Circle: MC VISA DISCOVER

Name on the Credit Card: ________________
Card Number: __________________________ CCV ________________
Expiration Date: ________________________

Address: ___________________________
Zip Code: ___________________________Email: _________________

I authorize the above credit card to be processed for this session and future sessions.
I understand that 24 hours notice is required to avoid a cancellation fee.
$10.00 NON- CASH RATE FEE or 5% (whichever processing fee is higher).
X____
*Zelle, cash, check is a lower rate. Please Zelle to audraboxma@yahoo.com ONLY