**CLIENT-CLINICIAN AGREEMENT**

**Tiffani Boykin, LPC, CCMHC**

**DC License #: PRC14155**

**CONFIDENTIALITY**: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law.

**When Disclosure Is Required By Law:** Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or ne-glect; where a client presents a danger to self, to others, to property, or is gravely disabled or when client’s family members communicate to me that the client presents a danger to others.

**When Disclosure May Be Required:** Disclosure may be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or my testimony. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. I will use my clinical judgment when revealing such information and will discuss this with you should it become relevant during your treatment. I will not release records to any outside party unless authorized to do so by all adult family members who were part of the treatment.

**Emergencies**: If there is an emergency during our work together, or if I become concerned about your personal safety, I may contact the person whose name you have provided on the biographical sheet. This includes the possibility of you injuring someone else. My action of using your emergency contact would be for the sole purpose of ensuring that you receive proper psychiatric care, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. I would abide by the limits of the law for disclosure of information about you in such a situation. When possible, I will make every effort to make you aware of the possibility of such a situation and would inform you if an emergency release if information occurred, even after termination.

**Health Insurance & confidentiality of records (DOES NOT APPLY TO CLIENTS PAYING OUT-OF-POCKET):** Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Ms. Boykin has no control or knowledge over what insurance companies do with the information he submits or who has access to this information.

**Litigation Limitation:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc..), neither you nor your attorney, nor anyone else acting on your behalf will call me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

**Mandated Clients:** Clients that are on probation or parole would require disclosure with regard to matter which may be confidential in nature. I will explain what type of information and with whom that information is shared once these legal mandates are discovered. You have the right to refuse service. In this circumstance, I will explain some potential consequences of refusing services.

**Therapy:** My approach to psychotherapy is eclectic to align with the client’s preferences. However, I lean towards solution focused brief therapy, cognitive behavioral therapy, and a wellness integrative approach. Essentially, my approach is experiential and constructivist because I believe the client is considered the expert and problems are resolved through therapeutic guidance and experiences that leads to changes in your thoughts, feelings, and perspectives that lead to a change in behaviors.

**Family & Couples:** When clients are engaged in couples or family counseling, the family or couple is the identified client. During these sessions I will not place the burden of the problem solely on the shoulders of one individual in the family and/or couple. Also in many circumstances secrets that are maintained can be damaging to the counseling process. I will not keep secrets that may be harmful to individual or relationships. However, I will make every effort to work collaboratively to help a client(s) discuss a sensitive or difficult topic with other family members.

**Consultation**: I consult regularly with other professionals regarding my clients; however, client’s identity remains completely anonymous, and confidentiality is fully maintained.

**E - Mails, Cell phones, Computers and Faxes**:

If you communicate with me via e-mail, I will assume that you have made an informed decision, and will view it as your agreement to take the risk that such communication is subject to third party interception. Unless you indicate otherwise I may use the email address you provide to communicate with you about appointments. It is my policy to send you an anonymous survey to you to receive feedback after your termination with me unless you instruct me otherwise.

**Records and Your Right to Review Them:** The law and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. I can generally prepare a summary for you instead. Because these are professional records, they can be misinterpreted by and/or upsetting to some people. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. When more than one client involved in treatment, such as in cases of couple and family therapy, I will release records only with the signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

**SCHEDULING APPOINTMENTS:** Appointments are usually set at the beginning of each session. If you would like to have a recurring or regular appointment, it is your responsibility to schedule in advance. My schedule is booked one month in advance at times and as such requires that you plan ahead. You may cancel previously scheduled standing appointments (*see cancellation policy).*

**TELEPHONE & EMERGENCY PROCEDURES:** If you need to contact me between sessions, please leave a message on my office voicemail (202) 753-9685 or confidential cell phone (202) 744-1393 and your call will be returned as soon as possible. On weekends I check messages and return most calls on *Sunday*.

If you need to talk to someone right away call:

Crisis Link (suicide and crisis hotline) for the Washington Metropolitan Area (free call): (202) 527-4077

Access Help Line (24/7 DC Mental Health including mobile psychiatric response units) 1-888-793-4357

Montgomery County Mental Health Hotline: 301-738-2255;

Prince George’s County Mental Health Hotline: 301-864-7161

Arlington County Mental Health (business hours): 703-288-1550

Police: 911

Please do not use e-mail for emergencies.

**PAYMENTS & INSURANCE REIMBURSEMENT:** The fees for consultation with **Tiffani Boykin** are as follows: Individual Counseling: $120 for 50 minutes and $200 for 80 minutes

Couples and Family Counseling: $250 for initial intake session 90 minutes and $150 minute per 60 minutes

Group Counseling: $50 to $75 per session

Payment is expected at the beginning of each session unless other arrangements have been made. Each year I evaluate my fees and may inform you of any change. You will be informed in writing of any fee increase 30 days beforehand. Telephone conversations (longer than five minutes), reports, or longer sessions will be charged at the same rate, per-minute, unless indicated and agreed upon otherwise. If requested, I will provide you with a copy of your billing statement on a monthly basis, which you can then submit to your insurance company for reimbursement if you so choose. If your account is overdue (unpaid) and there is no written agreement on a payment plan, I may use legal or other means (courts, collection agencies, etc.) to obtain payment.

**COUNSELING RELATIONSHIPS:** Not all dual or multiple relationships are unethical or avoidable. Therapy never involves sexual or any other previous relationship that impairs my objectivity, clinical judgment or could be exploitative in nature. I will assess carefully the risk and benefits before entering into non-sexual and non-exploitative “previous relationships” with clients. The Washington area has a dense set of social networks and some of my clients may know each other or know me from the community. Consequently you may see someone you know in the waiting room or see me in the community. I will never acknowledge working with anyone without his/her written permission.

Some of my clients choose me as their therapist because they knew me before they enter into therapy. If this is true for you, I will discuss with you the complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. “Previous relationships” can enhance trust and therapeutic effectiveness but can also detract from it and often it is impossible to know that ahead of time. It is your responsibility to communicate to me if the “previous relationships” becomes uncomfortable for you in any way. I will always listen carefully and respond accordingly to your feedback and will discontinue the previous relationship if I find it interfering with the effectiveness of the therapy or your welfare, and of course, you can do the same at any time.

**CANCELLATION:** Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hour notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

**AUTHORIZATION FOR CARE**

By signing below, I, the undersigned client and/or guardian verify that I have read, understand, and agree to the Client-Clinician Agreement form and I created by Tiffani Boykin, LPC, CCMHC.

I authorize Tiffani Boykin, LPC, CCMHC to provide the services of therapy to me and/or my child.

I understand that the therapy/counseling services provided to me are by appointment only and may not be available on an emergency basis.

I am aware of the cancellation policy and know that I will be charged for a full session if I miss an appointment or cancel within 24 hour notice.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Client/Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client/Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Client/Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client/Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tiffani Boykin, LPC, CCMHC Date