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PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

HIPAA REQUIREMENTS AND CLIENT RIGHTS

Welcome to my practice. **This Agreement is your "Informed Consent for Treatment," which will serve as an official contract between us. Informed consent is ethically and legally mandated by mental health licensing boards. You may terminate this Agreement in writing at any time.** As a client engaging in psychotherapy, you are entitled to receive information about the methods of therapy, the techniques used, and the expected duration of therapy. The law requires that I obtain your signature acknowledging that I have provided you with this information and that I provide you with a Psychotherapist-Client Service Agreement at the beginning of your therapy with me. We can discuss any questions you have about this material at any time. That termination will be binding on me unless I have taken action in reliance on it; or if you have not satisfied any financial obligations you have incurred.

HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of Protected Health Information (PHI) for treatment, payment and health care operations. This document contains a summary of information about HIPAA (Health Insurance Portability and Accountability Act), which is a federally mandated privacy act protecting patient rights with regard to the use and disclosure of your Protected Health Information (PHI) for the purpose of treatment, payment, and health care operations. In addition to the HIPAA brochure that I will provide you, the full document explains HIPAA and its application to your personal health information in greater detail. It is available on-line at: *http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html*

MY QUALIFICATIONS AND CREDENTIALS

I am a **Missouri, Kansas, and Colorado Licensed Clinical Professional Counselor (LCPC) and Licensed Professional Counselor (LPC), a National Certified Counselor (NCC) under the National Board for Certified Counselors (NBCC), and a PhD candidate (All But Dissertation) in Counseling Education and Supervision.** I conferred my Doctorate and Masters degrees from Walden University, a CACREP accredited program (Council for Accreditation of Counseling & Related Educational Programs). CACREP accreditation is considered the gold standard for licensed professional counselor's counseling education. Licensed Professional Counselors in the State of Missouri are regulated by: Committee for Professional Counselors, 3605 Missouri Boulevard, P.O. Box 1335, Jefferson City, MO 65102-1335, (573) 751-0018. **I encourage you to take a moment to provide anonymous feedback regarding your counseling experience by clicking on the survey link from the resources page of my website: *http://jeffpetersonphd.com/resources.html***

_____ Initials

PSYCHOTHERAPY SERVICES, GOALS, AND CLIENT EXPECTATIONS

Psychotherapy is an alliance between client and therapist that REQUIRES AN ACTIVE EFFORT ON YOUR PART. It is not like a medical doctor visit. Instead, it is process oriented, focused on increasing human understanding and bringing about gradual change. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. The specific experience of being in therapy varies depending upon the personalities of the psychotherapist and client and the particular problems a client is seeking to address. My training and experience in Mental Health Counseling is focused on a wide variety of clinical methods to help you deal with the problems that brought you to therapy. To facilitate the greatest possibility for success during therapy, I have several expectations of you and of myself.

CLIENT RESPONSIBILITIES: I expect each client who works with me to:

(A) **Participate actively in the therapeutic process by discussing realistic and concrete goals** to accomplish within a mutually agreed-upon time frame; and

(B) **Recognizing that change happens often requires personal work outside of the 50-minute session**, which may involve actively participating in homework assignments, bringing additional materials into the 50-minute session, and sharing what you have been working on between sessions.

THERAPIST RESPONSIBILITIES: Jeff agrees to practice within his level of competence, licensure guidelines, and ethical standards of practice.

(A) **Healing is a process, not an event, which requires a time commitment from both of us.** I am committed to promoting the principles of empowerment to help you work toward your goals for healing; and

(B) **I am committed to using therapeutic treatment approaches that strive to promote and sustain the highest level of functioning** for you throughout the course of your therapy.

(C) The State of Missouri requires that I disclose that in a professional relationship such as this one, sexual intimacy is never appropriate and should be reported to the regulatory board of the professional you are seeing.

BENEFITS AND RISKS OF THERAPUETIC PROCEDURES

- **Psychotherapy can have benefits and risks. Since therapy could involve discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness.**

- Recovering from trauma also sometimes involves going back through a stage that is less comfortable – moving from a numb state back to a state that is activated. The goal is to move through this with newly acquired coping skills that increase your distress tolerance

On the other hand, psychotherapy 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. Although there are no guarantees of what you will experience I will devote my attention to insure that we

maintain a safe and respectful environment that can maximize the possibilities for you to achieve positive growth and healing.

Our first few sessions will involve an evaluation of your needs. You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate this relationship at anytime. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. 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 my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETING LENGTH AND PROCEDURES

- **Sessions are generally 50 minutes in length, with the last ten minutes reserved for clinical documentation.**

- **Once an appointment hour is scheduled, you will be expected to pay for your session time unless you provide 24 hours advance notice of cancellation**.

- **You will also be expected to pay for your session time if you cancel two or more times in a row, regardless of advance notice of cancellation.**

The only exception is if we both agree that you were unable to attend due to circumstances beyond your control**.** If it is possible, and upon your 24-hour request, I will try to find another time to reschedule a missed or cancelled session as close to the time of your missed appointment, although you may still be charged for the missed appointment, especially if you cancel two or more times in a row.

- Upon request and with advance scheduling, **I may be available to conduct therapy sessions by phone when you have transportation restrictions, when you travel, or when a personal emergency precludes in person attendance at an appointment.**

As your therapist, I agree to appear on time for all scheduled sessions. If I do not show up for a scheduled session or do not provide 24 hours advance notification for the cancellation of an appointment, you will be given your next session free of charge. I normally consider the initial 2 to 4 sessions as an "evaluation period." During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, 50-minute sessions will be scheduled at a frequency that is mutually agreed upon. By mutual agreement, we may change the length and frequency of sessions at any time during the course of your therapy.

COMMUNICATION AND CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone, text, or email. When I am unavailable, my telephone is answered by a voice mail that I monitor frequently on weekdays between the **hours of 8:00 a.m. and 5:00 p.m. Monday-Friday**.

- **I am not available as an on-call provider, therefore there are times outside of my work hours that you may not be able to contact me, including weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call,**

contact your on-call family medical provider, or go to the nearest emergency room, or dial 911 and tell them you are having a psychiatric emergency.

- **I do not check email regularly, therefore the use of TEXT MESSAGING OR EMAIL IS TO BE USED FOR SCHEDULING PURPOSES ONLY. You should contact me by telephone or in person for any concern other than scheduling**. **Keep in mind that EMAIL IS OFTEN NOT A CONFIDENTIAL FORM OF COMMUNICATION.**

- **URGENT OR LAST MINUTE COMMUNICATION involving appointment changes or issues of distress should be handled thru my telephone voice mail and not via e-mail.**

I will make every effort to return your call within 24 hours (and on the same day whenever possible), with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. By signing this agreement you give me permission to leave you a voice message in the event that I am unable to reach you directly. Please let me know if you utilize a shared telephone or voice mailbox and if you would prefer that I not leave you any messages. If I plan on being unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Although I do have an e-mail address that is accessible through my website, I do not check e-mail messages with any specific regularity. I am often away from e-mail access for extended periods of time.

LIMITS ON CONFIDENTIALITY

When working with COUPLES, FAMILIES, OR GROUPS:

- **All participants agree to a "no secrets" policy where no information is withheld from one another**. No confidentiality will be exercised between the therapist and members of the couple, family, or group. This means that anything discussed individually between the therapist and an individual from a group, family, or couple, may be shared with all participants of the therapeutic relationship. Consent from all individuals within the group must be obtained in order to release these records to a third party.

The law protects the privacy of all communications between a client and a psychotherapist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent.

Meeting or Running into Each other in a Public Place:

- Please note that in order to maintain your privacy, **if we run into each other outside of this office, either in person: such as a public event, or virtually: such as an online forum, I will not engage you and I will not say hello, unless you decide to engage me first.** Also if I encounter or engage someone you know, I will not disclose to them the nature of our professional relationship.

YOUR SIGNATURE ON THIS AGREEMENT PROVIDES CONSENT FOR those activities, as follows:

- When engaging in email communication, on-line therapy using Skype, FaceTime, Google Hangout, telephone, text message, or any other electronic means of communication, **YOU AGREE TO WAIVE YOUR RIGHTS OF CONFIDENTIALITY and recognize that MOST ELECTRONIC FORMS OF COMMUNICATION ARE NOT CONSIDERED A HIPAA COMPLIANT OR CONFIDENTIAL FORM OF COMMUNICATION.**

- **I regularly consult with other health and mental health professionals about my client cases** as part of my continued growth and development as a clinician**.** During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychotherapist's Policies and Practices to Protect the Privacy of Your Health Information).

I AM LEGALLY OBLIGATED TO TAKE ACTION in some situations, which I believe are necessary to attempt to protect others from harm. I may have to reveal some information about a client's treatment, although these situations are unusual in my practice:

- **If you threaten to harm yourself during the course of your therapy work with me, I may be obligated to seek hospitalization for you** or to contact family members or others who can help provide protection

- **If you communicate an actual threat of physical violence against an identifiable victim**, I am required to take protective actions. These actions may include notifying the potential victim and contacting the police, and/or seeking hospitalization or detainment for you.

- **If I have reason to believe that a child has been or is likely to be subjected to incest, molestation, sexual exploitation, sexual abuse, physical abuse, or neglect**, the law requires that I immediately notify the Division of Child and Family Services or an appropriate law enforcement agency and provide ongoing information as needed.

- **If I have reason to believe that any vulnerable adult (such as an elderly or impaired individual) has been the subject of abuse, neglect, abandonment or exploitation**, I am required to immediately notify Adult Protective Services and provide ongoing information as needed.

I AM PERMITTED OR REQUIRED TO DISCLOSE information without either your consent or Authorization in some situations:

- If you are involved in a court proceeding **I cannot provide any information without your (or your legal representative's) written authorization, or unless I receive a court order.** If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- **If a government agency is requesting the information for health oversight activities**, I am required to provide it for them.

- **If you file a complaint or lawsuit against me, I may disclose relevant information regarding your therapy** work with me in order to defend myself.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and in situations where specific advice is required, formal legal advice may be needed.

GROUP THERAPY – LIMITATIONS OF CONFIDENTIALITY

Group therapy has unique dynamics when compared to individual therapy. While the confidentiality between you and the group facilitator are protected by the therapist/client relationship, confidentiality is not protected between you and other group members. Therefore when you enter group therapy you acknowledge that:

- You agree to keep the content of group sessions and the identity of group participants confidential and agree not to share information from the group with anyone outside of group. Members who violate this policy are subject to being dismissed from the group without refund at the discretion of the group facilitator

- You recognize that confidentiality can not be guaranteed, as there are no legal protections preventing group members from disclosing information to someone outside of the group

- Because of this limitation of confidentiality, group members disclose information at their own risk and avoid disclosing information that could compromise their safety or well-being

- You agree that your email can be shared with other group members as part of networking and disseminating group materials

GROUP THERAPY – ENTERING AND EXITING

When group members enter and exit the group it places a strain on the participants who are part of the remaining group. This is because they have to adjust to getting to know and trust the new member, which affects the dynamic of the group's cohesion. Therefore in order to reduce this strain, new group members who enter group therapy must adhere to the following agreements:

- You agree to commit to a subscription of a minimum of 5 sessions when beginning group

- When you decide to discontinue your group therapy subscription you agree to give the group and group facilitator a minimum of 2 weeks notice prior to the end of the pre-paid term

- You agree to attend group and participate in the group on a regular basis. Members who do not participate may be asked to leave at the discretion of the group facilitator

- You understand that if you leave the group and then decide to return at a later date entry to the group is not guaranteed and is subject to availability

GROUP THERAPY – RULES AND AGREEMENTS

- Group members agree to adhere to the group norms and rules established by the group and group facilitator. This includes: a) demonstrating respect towards others, b) valuing cultural differences between group members, and c) focusing on sharing your own experiences rather than giving advice to others

- The group is limited to 8 members and your pre-payment reserves your spot within the group. Vacations or times of absence require a continued paid subscription in order to hold your spot in the group.

- Group members will be charged for the following month's subscription one week prior to the beginning of a new pre-paid term

MINORS & PARENTS

Clients under 12 years of age who are not emancipated from their parents should be aware that the law may allow parents to examine their child's treatment records unless I decide that such access is likely to injure the child, or we agree otherwise. Since parental involvement in therapy is important, it is my policy to request an agreement between a child client between 12 and 18 and his/her parents, allowing me to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

PROFESSIONAL RECORDS AND TRANSFER PLAN

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others, or where information has been supplied to me confidentially by others, **you may examine and/or receive a copy of your Clinical Records, if you request it in writing.** Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. I do bill for my regular therapy fee for such review meetings. In most situations, I do charge a copying fee of $.25 per page (and for certain other expenses). If I refuse your request for access to your records, you have a right of review or appeal (except for information supplied to me confidentially by others), which I will discuss with you upon request. **It is your responsibility to maintain and update your contact information with me, regarding your phone number, email, and address.**

In the unlikely event that I should become incapacitated, die, or otherwise disappear, the following transfer plan is in effect for the storage and accessibility of your professional records. **The custodian of your professional records shall be: George M. Wine Chase, M.Div., M.S. L.P.C., 9233 Ward Parkway, Suite 305, Kansas City, MO 64114, gwinechase@gmail.com, 816-824-9898.**

CLIENT RIGHTS TO PROFESSIONAL RECORDS

HIPAA provides you with several rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; 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 my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

PROFESSIONAL FEES

My standard hourly fee is $150. If I have agreed to charge you a rate below the standard amount, the reduced rate is subject to change without notice. In addition to weekly appointments, I charge my standard rate (regardless of our agreed or reduced amount for therapy) for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour**.** Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party.

BILLING AND PAYMENTS

You must pay for your session in advance prior to making an appointment on my calendar, unless we agree otherwise. When you agree to make a pre-payment:

A) You agree that all pre-paid sessions are NON-REFUNDABLE.

B) You commit to schedule the pre-paid therapy session(s) within 1-year. PRE-PAID SESSIONS EXPIRE after 1-year from when the payment is made. REFUNDS WILL NOT BE MADE for any unused sessions (group, individual, or family), unless I am no longer able to provide these services.

C) You consent to release personal information necessary to complete billing and appointment reminder services to the companies who provide these services (credit card processing & appointment reminder services).

In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

ENDING THERAPY

I am committed to working with you as long as the therapeutic process is productive and healthy. The process of ending therapy may be equally as significant as the work you accomplish during the course of your therapy. The ending of therapy is most impactful when it evolves from a partnership between client and therapist.

- **I ask that if you decide to terminate therapy please communicate this to me either in person, over the phone, via email, or in-person.** I am available at any time during the therapy process to discuss concerns you may have regarding the ending of your therapy. It is most productive if you can address the ending of your therapy over the course of several closure sessions.

- **If I do not have contact or communication from you for a period of 30 consecutive days, I will assume that you no longer intend to remain an active client and your records will be closed.** If you decide to return to therapy, we can re-open your existing client files anytime within an 8-year period.

ACKNOWLEDGEMENT THAT YOU HAVE READ AND UNDERSTAND THE PSYCHOTHERAPIST-CLIENT AGREEMENT:

I (printed name)_____ consent to the counseling services of Jeff Peterson in accordance with the Psychotherapist-Client Services Agreement will assume financial responsibility for the cost of our counseling sessions.

_____ _____
Signature Date

_____
Date of Birth

_____ _____
Parent/Guardian (if applicable) Date

HIPAA FORMS ACCESSED OR RECEIVED:

My signature below indicates that I have received a copy of the *Psychotherapist-Client Agreement* and have been given access to a copy of the *HIPAA Notice of Psychotherapist's Policies and Practices to Protect the Privacy of Your Health Information* document.

_____ _____
Signature Date

_____ _____
Parent/Guardian (if applicable) Date