CALISSA'S COUNSELING SERVICES

3580 Main St♦Building #11♦Suite E♦Hartford, CT 06120
Phone: (860) 778.5317♦ Fax: (860) 219-0100
www.calissascounseling.com

Service Agreement/Treatment Consent

Welcome to my practice. The decision to begin psychotherapy can be a difficult one. By making this decision, you have made a commitment to your emotional well-being and to improvements in your relationship with others. You may have also made a commitment to your child's mental health and functioning. Research has shown that individuals entering therapy achieve favorable results when they have a clear understanding of what to expect.

The following material will provide you with important information about professional services and business policies. It also contains information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The notice of Privacy Practices, which is attached to this agreement, explains HIPAA and its application to your personal health information. The law requires that I obtain your signature acknowledging that I have provided you with this information by the end of the first session.

Counseling Services

Psychotherapy calls for an active effort on your part. In order for counseling to be most successful you will have to work on the things we talk about during our session at home. In addition, your responsibilities are to provide relevant, accurate and complete information as to your history, symptoms, complaints, medication, and current status. Please make your best efforts to have relevant information (such as previous psychiatric evaluations, discharge summaries, school reports, etc.) ready at the time of your first session.

As your therapist, I have the responsibility to ask you questions about you and your family's history, as well as your feelings and actions. I also have the responsibility to provide you with direct information about treatment as well as my clinical recommendations. If you choose to terminate treatment, I can assist you in developing appropriate options, unless you choose otherwise.

Individual and family sessions are 45 minutes in length. It is important for us to end on time, so I am able to document our session, review records and/or make collateral phone calls on your behalf. The frequency of sessions depends on clinical need and can be discussed at your first session and re-evaluated at subsequent sessions.

Office Policies

My usual and customary fee for your first appointment, described as the "diagnostic assessment" or "intake" is $175.00. All other sessions (individual, family, collateral) are charged at $125.00 per session. Special evaluations/assessments (e.g. school/court related) are billed according to the breadth of the evaluation, duration of evaluation, and whether or not a formal report is required.

Co-payments/session fees are due at the time of service. All payments for services are to be made by personal check, cash, or credit card. If your insurance company is being billed, I will make appropriate efforts to obtain payment; however, you as the client are responsible for any outstanding charges that are not covered. A service fee of $25.00 per month shall apply to any accounts for which there is an outstanding balance, including payments which are late, or if there has been no payment made by you or your insurance company on the balance within the past 30 days.

If your account has not been paid for more than 60 days and arrangements for payments have not been

agreed upon, I have the option of using legal means to secure payment. By signing this agreement, you understand that you are responsible for reasonable attorney and legal fees for accounts that go to collections.

If you need to cancel an appointment, it must be done with 24 hours' notice. If this does not occur, a cancellation/no-show fee of $50.00 will be billed to you personally. Furthermore, due to the importance of consistency in therapy, three or more late cancellations and/or no-shows may result in the discontinuation of care.

Any service requested by you the client (e.g., court testimony, written treatment summaries/recommendations, attendance at PPT meetings) is billable to you personally at the regular session rate of $125.00 per hour.

If you have a brief, routine message please call and leave the message on my voice mail. If you are having a mental health emergency, or require urgent care, please call your local emergency services or proceed to your local emergency room. I check my voice mail twice per day and cannot guarantee that I will be readily available. I try to return messages within one business day. Phone calls are not to take place of a regular counseling session.

Limits of Confidentiality

The confidentiality of your records is highly valued. The law protects the privacy of communications between a client and therapist, although law excludes some situations. 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 and/or other federal or state laws.

Limits to preserving confidentiality include the following:

1. If you have a health insurance policy, it will usually provide some coverage for mental health treatment or assessment. If you choose to use this mental health coverage, your insurance company, external gatekeeper, and quality assurance committee may review your records for quality and/or appropriateness of care. Required information regarding the state of care may also be released to your insurance company to facilitate payment.
2. If I know or have reason to suspect that a child under 18 years of age is being or has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law mandates that I file a verbal and written report with the Department of Children and Families. Once a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the client, other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim(s), and/or appropriate family member(s), and/or the police.
    a. such a situation arises, I will make a reasonable effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

Clinical Records

The laws and standards of my profession require that I keep Protected Health Information about you in your clinical records.

Except in unusual circumstances that disclosure would potentially endanger you and/or others, or the information makes reference to another person (other than a health provider), or I believe access is reasonably likely to cause you or others substantial harm, you may examine and/or receive a copy of your

clinical record, if you request it in writing. Clinical records may be misinterpreted or upsetting to an untrained reader. For this reason, I recommend that you initially review them in my presence or have me forward them to another mental health professional, so you can discuss the contents.

Client Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of Protected Health Information (PHI). These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to, nor authorized; determining the location to which PHI 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, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Minors and Parents

Parents of clients under the age of 18 who are not emancipated should be aware that the law may allow parents to examine their child's treatment records. Children between the ages of 13 and 17 may independently consent to (and control access to the records of) diagnosis and treatment in a crisis situation. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, I may request an agreement with minors (over 12) and their parents about access to information. This agreement provides that during treatment, I will provide parents with only general information about the progress of the treatment and the child's attendance at scheduled sessions. I may also provide the parents with a summary of their child's treatment when it is complete. In these cases, I may require the child's authorization to release information, unless I feel the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concerns. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to manage any objections he or she may have.

The federal law protecting the release of drug and alcohol information is more stringent for adults and minor children. While I recognize the serious parental concerns in this regard, I cannot release such information without informed consent from an adult client, as well as children 14 years of age and older.
By presenting your minor child for treatment, you are representing and affirming that you have legal parental authority to do so. Unless parental rights have been terminated, or there have been other restrictions imposed by the court or law, you are affirming that both parents have equal rights to information about diagnosis and treatment under the law.

Complaints about Services

I strive to provide quality services in a caring and professional manner. I understand, however, that disagreements or complaints can occur. I encourage you to discuss these directly with me in order to rectify the matter. I will make every effort to address your concerns; however, if you find the issue unresolved, you may file a complaint with the Secretary of Health and Human Services for the State of Connecticut.

Service Agreement/Treatment Consent Acknowledgement

I HAVE READ, AND I UNDERSTAND THE ABOVE INFORMATION AND BY SIGNING THIS FORM I ACCEPT AND FULLY AGREE TO BE TREATED ACCORDING TO THE ABOVE CONDITIONS AND CLIENT/THERAPIST RESPONSIBILITIES.

_____ _____

Print Name (Client) **Date**

_____ _____

Signature of Client **Date**

_____ _____

Print Name (Parent/Guardian) **Date**

_____ _____

Signature of Parent/Guardian **Date**
(Mandatory for clients under the age of 16)

_____ _____

Signature of Witness (Clinician) **Date**