CONTRACT, OFFICE PROCEDURES & FINANCIAL AGREEMENT FOR PSYCHOTHERAPY SERVICES

Welcome to T.H.E. - TRUTH, HEALING & EVOLUTION COUNSELING SERVICES. This document contains important information about TRUTH, HEALING & EVOLUTION COUNSELING SERVICES professional services and business policies. We are governed by various laws and regulations and by the code of ethics of our profession. The ethics code requires that we make you aware of specific office policies and how these procedures may affect you. Therefore, we are providing this information in writing. We encourage you to take the time to read through this carefully. When you sign this document, it will represent an agreement between you and TRUTH, HEALING & EVOLUTION COUNSELING SERVICES.

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TRUTH, HEALING & EVOLUTION (T.H.E.) is a counseling center that offers educational, therapeutic, and life coaching services.

T.H.E. **employs Marriage and Family counselors** who are either:
a) Licensed by the State of California, and are practicing therapists;
b) Licensed/Registered Social Worker, and are practicing therapists;
c) Graduate interns who have a Master's degree and are working towards completing their hours for licensure; and
d) Trainees who are working towards the completion of their Master's degree program in counseling or social work.

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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 (client's) 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 neglect; where a patient presents a danger to self, to others, to property, or is gravely disabled.

Initial here: _____

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. 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 testimony by T.H.E. counselor. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. T.H.E. counselors will use their clinical judgment when revealing such information. T.H.E. will not release records to any outside party unless they are authorized to do so by all adult family members who were part of the treatment.

Initial here: _____

Health Insurance & Confidentiality of Records: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that is designed to protect the privacy of patient information, provide for the electronic and physical security of health and patient medical information, and simplify billing and other electronic transactions by standardizing codes and procedures. A piece of this law recently took effect and is known as the HIPAA Privacy Rule. The HIPAA Privacy Rule creates a minimum federal standard for the use and disclosure of Protected Health Information (PHI) by health care organizations. One of the requirements of the Privacy Rule is that we give to you a

Notice of Privacy Practices (NPP) that describes your rights and protections regarding your health care records (PHI). The Notice explains your rights regarding your private healthcare information, including your right to:

- Inspect and copy your medical records;
- Request an amendment or addendum to your medical records;
- An accounting of disclosures of your private health information;
- Request restrictions to release your medical information; and
- Request restrictions of confidential communications with you.

By signing this contract, you are consenting to a release of information about your case to your health plan for claims, certification and case management for the purposes of treatment and payment. T.H.E. has no control or knowledge over what insurance companies do with the information that is submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance.

I have reviewed and understand T.H.E.'s HIPAA policies- Notice of Privacy Practices and have been made aware of how my records may be used and disclosed.

Signature of Client/Responsible Party_____

Print Name _____

Date _____

TELEPHONE, EMAIL & EMERGENCY PROCEDURES:

- The *best way to communicate with Truth Healing & Evolution is via Email* truthhealingevolution@gmail.com, *please allow 48 to 72 hours to receive a response.*
- *If Wendy Whitmore MS LMFT, is your therapist please send a text to 909-576-5431. If it is an emergency please indicate it clearly in your message.*
- ***If you find that you are in a crisis and you are in imminent danger, call the police (911), or go immediately to your local emergency hospital.***
- If you need to contact your therapist between sessions, send them a text and indicate it clearly in your message what it is that you are in need of. Telephone calls & text messages are monitored during the day as time allows and therefore, we cannot guarantee immediate return calls. T.H.E. counselors are not responsible for your behaviors or decisions occurring outside the consultation room, whether before or after a telephone call or consultation.
- If there is an emergency whereby an T.H.E. counselor becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, the counselor will do whatever he/she can within the limits of the law, to prevent you from injuring yourself or others; and to ensure that you receive the proper medical care. For this purpose, the counselor may also contact the person whose name you have provided as an
- **Emergency Contact Name:**
- **Emergency Contact Number:**

Initial here: _____

INFORMED CONSENT FOR TELEPHONE, ELECTRONIC, AND MAIL CONTACT:

Ordinary privacy precautions such as voice scramblers, pin codes, voice mail boxes, and locked fax, mail, and computer rooms are by no means foolproof, so that your confidentiality is always compromised when communicating by electronic devices or mail. Nor is deletion or shredding of private material a totally safe means of disposal, so that you are always at risk of breaches in confidentiality when electronic or mail communication of any type is used for private information. Your use of such means of communication with constitutes implied consent for reciprocal use of electronic and mail communication as well. By signing this contract, you agree to and understand the following:

1. Many people feel comfortable communicating via email, because they have installed programs designed to detect spy ware, viruses, or other dangerous software. However, there is no guarantee that such programs will work 100%.

2. Sent and received emails are stored on both T.H.E. and your computer until deleted. T.H.E. may or may not delete such emails. Any saved emails will be kept in a password-protected account that only T.H.E. has access to.

3. In addition, whenever you send an email, it is stored in cyberspace. It is possible for authorities to locate and read such emails under various circumstances, this is not a policy of T.H.E., but is due to the nature in which email is transmitted using the Internet, and other services or networks.
For more information on this, please contact your Internet Service Provider or email service.

4. By initialing below, I agree that I understand the disclosures listed above regarding communicating with T.H.E. using email. I also agree that if I send an email to an T.H.E. counselor and request a response via email, that I am willing to accept the above-stated risks. I also agree that I will not use email for emergencies.

Initial here: _____

Permission for T.H.E. to initiate emails & text messages to you:

Initial below if you give your permission for T.H.E. to initiate sending emails & text messages to you.

Initial here: _____

EMAIL: _____

CONSENT TO TREATMENT AND CONFIDENTIALITY STATEMENT:

I, (print name of responsible party) _____
consent for treatment to be rendered by a therapist of TRUTH, HEALING & EVOLUTION I grant the therapist to perform those procedures and treatments, which may include professional consultation or emergency telephone responses, necessary for my condition that are generally used in this and similar settings. I understand that information or opinions will be given to others only with my written consent.

Signature of Client/Responsible Party Print Name Date

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APPOINTMENTS: All office visits are by appointment and may be scheduled through the office manager or your counselor directly. Because consistency is an important part of the counseling process, the appointment time you schedule is reserved for you and is not available to anyone else. Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is 50 minutes. If you are unable to keep a scheduled appointment, you must notify T.H.E. **at least 24 hours in advance** to avoid having to pay for the canceled or missed appointment. Please leave a message if you get the voice mail. If you miss or cancel your appointment, you will need to contact the office for a new appointment time.

Cancellation Policies: Since scheduling of an appointment involves the reservation of time specifically for you, **a minimum of 24 hours notice** is required for rescheduling or canceling an appointment.
You will be charged for the full amount of a scheduled fee without such notification.
Most insurance companies do not reimburse for missed sessions.

Your compliance in keeping appointments and active participation in treatment is vital.

Initial here: _____

DISCLAIMER

As a courtesy Truth Healing & Evolution will verify your eligibility and benefits; however it is strongly suggested that you contact your insurance to verify your coverage; i.e. deductible, copay, and keep up with when deductible has been met.

PAYMENT & INSURANCE REIMBURSEMENT:

- Clients paying on a ***cash basis***, and not billing any insurance company are expected to ***pay in full at time of service*** unless other arrangements have been made.
- Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable.
- **Insured clients are expected to take care of their fees as services are rendered.** Your health insurance may help you recover some of your counseling costs. Most group policies, but few individual policies cover outpatient psychotherapy. Please verify with your company the amounts of coverage for outpatient psychotherapy. If your policy requires pre-authorization to receive services, this is your responsibility and needs to be handled before your first visit.
- Our office will bill your insurance company for services provided. You will receive a statement each month reflecting any balance due on your account. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. You are responsible for payment, deductible, and insurance claims on your account.
- ***Clients are personally responsible for all payment of fees, including those not paid by their insurance carrier within 30 days after the rendering of services. IF YOUR INSURANCE FAILS TO PAY THE BALANCE YOU WILL BE BILLED AND WILL HAVE TO COLLECT THE REMAINING BALANCE FROM YOUR INSURANCE PROVIDER.***
- The client portion (co-pay) of fees is expected at the time of service. ***CO-PAYS ARE NOT NEGOTIABLE****. Failure to pay your part may jeopardize your benefits*.
- ***Additional fees*** are charged for **lengthy telephone communications ($45 per 30 MINUTES $85 per HOUR)**, **court attendance $150/HOUR (PAID BY YOU) and report/letter writing $150/LETTER WRITTEN)**. ***PLEASE NOTE YOUR INSURANCE DOES NOT COVER THIS.***
- There is a ***$30.00 service fee*** **for checks returned** for non-sufficient funds, and the client will be required to pay for future sessions in cash. Before any future visits occur, the client or responsible party must pay ***in cash*** the service charge ***PLUS*** the value of the check.
- At any time during treatment ***should the client become ineligible for insurance coverage****, the client and/or responsible party agrees to notify the counselor and* ***will be responsible for 100% of the bill.***

Initial here: _____

Collection Policy: Our office retains a professional collection agency for pursuit of accounts that become delinquent. If it becomes necessary to transfer your account to our collection agency, your financial records will be released to them and your delinquent balance will be recorded with the three (3) major credit bureaus, i.e., Trans Union, Equifax, and Experian.

- Accounts become ***delinquent after thirty (30) days***. Delinquent accounts may be turned over for collection.
- A ***12% fee*** will be added for balances ***over 30 days*** old.
- If legal proceedings become necessary, the client hereby agrees to bear ***all financial responsibility*** for all attorney and court costs associated with collecting an unpaid debt. Please be aware that we take this action only as a last resort.

Initial here: _____

Appeals And Grievances: I acknowledge my right to request reconsideration (an Appeal) in the case that client care is not certified by Managed Care Company. I understand that I would request an Appeal directly through my Managed Care Organization.

I also understand that I may submit a Grievance to my practitioner at any time to register a complaint about my care or I may send the complaint directly to my insurance company. My practitioner has access to information to facilitate this.

I understand that the California Department of Manages Health Care (DMHC) is responsible for regulating health care services. The California DMHC has a toll-free telephone number (800-400-0815) to receive complaints regarding health care plans. If I have a grievance about an appeal that has not been satisfactorily resolved by the plan I can contact the Managed Care Company of the DHMC.

Initial here: _____

Consent To Treatment And Fee: By signing this contract, you agree that if you have not obtained any necessary authorizations from your insurance, or are not eligible at the time services are rendered, **you are responsible for payment** even if the determination is made after the services are rendered. Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company.

I hereby agree to full responsibility for all expenses incurred by or because of this client and hereby assign TRUTH, HEALING & EVOLUTION COUNSELING SERVICES and all insurance benefits due to me to the full extent of my financial obligation to T.H.E. I understand my insurance coverage is a relationship between my insurance company and me and I agree to accept financial responsibility for payment of charges incurred. I understand that a re-billing fee/financial charge complying with California State Law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. If conjoint (couple or family), all adults need to sign this contract because of confidentiality and your rights... even though one person is the identified client (and paying).

Signature of Client/Responsible Party _____

Print Name _____

Date _____

THE PROCESS OF THERAPY/EVALUATION: By signing this agreement you are authorizing and requesting that T.H.E. carry out counseling treatment and/or diagnostic procedures that now or during the course of your care as a client are advisable. Participation in therapy can result in a number of benefits, including improved interpersonal relationships and resolution of the specific concerns that led you to seek therapy.

Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. T.H.E. will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. T.H.E. may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes another family member views a decision that is positive for one family member quite negatively. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, T.H.E. is likely to draw on various psychological approaches according, in part, to the problem that is being treated and an assessment of what will best

benefit you. These approaches include behavioral, cognitive-behavioral, psychodynamic, existential, system/family, developmental (adult, child, family), or psycho-educational.

- I understand that if I am concerned about slow progress or lack of progress I have the right to speak about my concerns.
- I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.
- I understand that there are some occasions when confidentiality can/must be breached. These are:
    - a) I sign a *Release of Information Form* or I verbally direct my counselor to tell someone else,
    - b) My counselor determines that his/her client poses a threat to self or others,
    - c) My counselor is ordered by a court to disclose information,
    - d) My counselor suspects child abuse has taken place and will notify Child Protective Services, or
    - e) Forensic consultation or treatment ordered by the courts.
- I understand that counseling can improve as well as upset the equilibrium in any person or family.
- I understand that T.H.E. counselors are not psychiatrists, they are Master's level therapists, and as such cannot recommend or prescribe medications but can encourage clients to see an M.D. for a medical evaluation.

Initial here: _____

Rights and Risks:

- Please feel free to ask questions about any aspect of the counseling process. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, the T.H.E counselor's expertise in employing them, or about the treatment plan, please ask and you with be answered fully.
- If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report.
- You need to be willing to discuss what troubles you and be open to change.
- You may remember unpleasant events, arouse intense emotions, and/or alter close relationships.
- You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that T.H.E. does not provide, the therapist has an ethical obligation to assist you in obtaining those treatments.

Initial here: _____

PROFESSIONAL RECORDS: The laws and standards of the profession require that T.H.E. keep treatment records. You are entitled to receive a copy of your records, or your therapist can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, we recommend that you review them in the presence of your counselor so that she/he can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

Initial here: _____

TERMINATION:

- An orderly end of therapy has positive effects for clients. It is suggested that you discuss openly with your counselor your wish to end therapy at least three (3) sessions before your last session. A final closure session has proved to be very important for clients. Closure sessions help you acknowledge and summarize what you have accomplished and discuss any unfinished concerns you may have. While not required they are strongly

recommended; you have the right to terminate therapy at any time. If you choose to do so, T.H.E. will offer to provide you with names of other qualified professionals whose services you might prefer.

- If at any point during psychotherapy, an T.H.E. counselor assesses that she/he is not effective in helping you reach the therapeutic goals, they are obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, the counselor would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, the T.H.E. counselor will talk to the psychotherapist of your choice in order to help with the transition.
- If at any time you want another professional's opinion or wish to consult with another therapist, T.H.E. will assist you in finding someone qualified, and with your written consent, will provide her or him with the essential information needed.
- If you don't show-up for three consecutive scheduled appointments, your treatment will be considered canceled and terminated and you will be financially responsible for the fees of the missed sessions. A letter will be sent to you acknowledging the termination along with a closing bill for any unpaid balance.

Initial here: _____

Consent: In order to evaluate our services may we have permission to contact you once you have completed your counseling with the understanding your response will be held confidential?
____Yes ____No

Initial here: _____

I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with.

Signature of Client/Legal Representative _____

Print Name _____

Date _____

Additional Client Signature (Spouse, /Partner, Family Member) _____

Print Name _____

Date _____