

IMPORTANT INFORMATION, CLIENT CONSENT TO TREATMENT, AND FEE AGREEMENT:

Please read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and Dr. Christy have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Dr. Christy can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor are any sorts of trade of service for service.

AVAILABLE SERVICES: Dr. Christy offers individual therapy for children adolescents, and adults. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is the intent to convey the policies and procedures used in this practice. We can discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. These benefits cannot be guaranteed, of course. The desire and intention is to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: Dr. Christy provides counseling designed to address many of the issues clients experience. Your first visit will be an assessment session in which you and Dr. Christy will discuss your concerns. If both agree that Dr. Christy can meet your therapeutic needs, a plan of treatment will be developed within three sessions. Should you choose not to follow the plan of treatment provided to you by Dr. Christy, services to you may be discontinued. Dr. Christy's goal is to provide the most effective therapeutic experience available to you. If at any time you feel that the relationship is not a good fit, please discuss this matter with Dr. Christy to determine if referral to a more suitable therapist is right for you. If you and Dr. Christy decide that other services would be more appropriate, she will assist you in finding a provider to meet your needs.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule may be available if determined appropriate by Dr. Christy. If you must cancel or reschedule your appointment, we ask that you call at least 24 hours in advance. This will free your appointment time for another client. ***If you fail to cancel an appointment or cancel without 24 hour notice, you will be responsible for paying a fee of \$75.00, which must be paid before another appointment may be scheduled.***

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. In the event you must miss your appointment, please contact Dr. Christy as soon as possible. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, Dr. Christy will make every effort to respond to your emergency in a timely manner. In the case of inclement weather, please call if you must cancel. If Dr. Christy is unable to get to the office, she will call and cancel your appointment as soon as she is able.

STANDARD FEE SCHEDULE:

Diagnostic & Evaluation Session (1 st visit)	\$ <u>195.00</u>
Regular Office Visits (60 minutes)	\$ <u>175.00</u>
Brief Office Visit (45 minutes)	\$ <u>130.00</u>
Missed appointment fee (under 24 hrs)	\$ <u>75.00</u>
Returned check fee per check	\$ <u>30.00</u>

*For some clients who elect to pay for their treatment, a reduced fee schedule may apply and may be discussed with Dr. Christy

A reasonable fee will be charged for copies of any records requested by the Client.

PAYMENT/INSURANCE FILING: *Payment of fees, including any required deductible or co-pays, is expected at the time of each appointment before your session begins.*

If you are using insurance benefits, and Dr. Christy is a contracted provider for your insurance company, she will file insurance claims for you. If you wish to file your own claim, full payment is expected at the time of service, and you will be provided with a statement for services rendered.

If Dr. Christy is in network and contracted with your insurance company, you are responsible for the difference between the amount of insurance reimbursement and the contracted rate. Dr. Christy will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements.

If Dr. Christy is not in network with your insurance company, and your company agrees to pay out-of-network, you are responsible for the total amount of any deductible required by your carrier at the full, standard rate above. After such deductible is satisfied, you remain responsible for the difference between the amount of insurance reimbursement and the standard fees.

CONFIDENTIALITY: Dr. Christy follows all ethical standards prescribed by state and federal law. She is required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent *unless mandated by law*. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to Dr. Christy's attention so you and she may discuss this matter further. By signing this Information and Consent Form, you are giving consent to the Dr. Christy to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding Dr. Christy harmless from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: *If there is reason to believe that you (or your child if he/she is the client) are a danger to yourself or another human being, or a child (age 17 or younger) has been neglected or abused, or engages in sexual activity, your therapist is mandated by law to act to protect.*

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

*NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child’s mental health care and treatment, Dr. Christy will not render services to your child until she has received and reviewed a copy of the most recent applicable court order. If separated or unmarried parents share joint custodial rights, both parents must agree to services.

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of Dr. Christy, it will be necessary for another individual, selected and coached in confidentiality laws by Dr. Christy, to have possession of my treatment records. By my signature on this form, I hereby consent to another individual to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

I HEREBY AUTHORIZE THE RELEASE OF NECESSARY MEDICAL INFORMATION FOR INSURANCE REIMBURSEMENT PURPOSES AND PAYMENT OF MEDICAL BENEFITS TO THE PROVIDER OF SERVICES.

Client/Parent

Date

Therapist

Date