Total Wellness Consultants

Rebecca S. Harvey, Psy.D.
Licensed Psychologist
Lic: TX36035

INFORMED CONSENT AND AUTHORIZATION FOR PSYCHOTHERAPY

Relationships tend to bring out our personal issues. The relationship between you and your therapist is designed to do exactly this; your problems and difficulties will be explored in the context of the therapeutic relationship. While I am trained in several different orientations and styles of therapy, I most frequently use a combination of existential psychotherapy and a neurobiology-based mindfulness approach. Should you choose to begin therapy, a positive outcome then becomes our mutual responsibility.

While benefits are expected from therapy, specific results are not guaranteed. Therapy is a personal exploration and may lead to changes in your life views and choices. Often growth cannot occur until you experience and confront issues that may result in a level of emotional distress. The success of our work depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy.

Your agreement is to trust in and commit to the treatment process. My agreement and commitment to you is to address your concerns and questions while treating you with respect, compassion and understanding. The goal of therapy is to help you move closer to your goals, even as they develop or evolve in treatment. This may include finding greater peace and awareness of your thoughts, feelings, actions, and beliefs.

In addition to the therapeutic process, therapy involves a professional arrangement, regulated by laws, ethics, your rights as a client, and my standard business practices which will be outlined below.

As a standard business practices, each appointment ends 53 minutes from the scheduled start of the appointment, regardless of your arrival time. I am not able to extend sessions since appointments begin on the hour.

Paying for therapy is often a very sensitive topic, and we can discuss your concerns about payment as needed. This section clarifies all fees, and defines your financial responsibilities.

PAYMENT PRACTICES

1. The fee for the initial "intake" session is $225, as session requires more work outside of our face-to-face time. Unless otherwise established, the standard fee for sessions going forward is $210.00 per (50 minute) individual session and $300.00 per (75 minute) couples therapy session, payable following each session. A $35.00 returned-check fee will be applied to any insufficiently funded checks.

2. Canceling or rescheduling appointments requires **a 24 hour notice by telephone** to avoid having to pay the entire fee for a missed session. No e-mail please—I do not typically have time to check email during my work day. **If you typically file to your insurance, please note that a missed session cannot be billed to your insurance. Therefore, cancellations of less than 24 hours will result you paying out of pocket the full standard fee of $210.**

3. For reasons we can discuss, I do not get involved in determining what constitutes an "emergency" in your life and normally, payment for last minute cancellations is required. Y**ou will be required to place a credit card on file to cover the cost of any missed sessions. Additionally, habitually missed sessions may result in the need to terminate our therapeutic relationship.**

4. Written reports of any type are billed to you at $300.00/hr.

5. Telephone conversations between us, for any reason, in excess of (15) minutes per day may be billed as a partial therapy session and be billed to you in proportion to your hourly fee.

6. I do not involve myself in legal proceedings under voluntary circumstances. This includes custody matters. If you become involved in legal proceedings that require my participation, this is not covered by insurance and due to the difficulties of legal involvement is billable to you at $450.00/hr (with a minimum of three hours). This fee is for all of my professional time, including preparation, report writing and transportation as well as the entire time spent away from the office. **This applies even if I am called to participate by another party.** I must plan in advance to be away from the office and cancel existing appointments. Thus, I require a retainer of $1000 and in the event of cancellation, I require 48 hours advance notice. If 48 hour notice is not given, this will result in your forfeiting the retainer fee.

7. You shall provide your therapist with any changes regarding insurance benefits, address, phone number, contact information or business affiliation during the time period which your therapist's services are required.

REGARDING INSURANCE:

8. While I do not work directly with insurance providers, I may offer to assist you with being reimbursed by any benefits you may have, by filing to your insurance company on your behalf. This does not include direct communication with your insurance provider, only electronically submitting. **It is your responsibility to be aware of your own insurance benefits.**

9. I cannot submit to your insurance for reimbursement if you do not attend your session. Any fees associated with missing your scheduled session will billed to you, not reimbursable by your insurance provider.

CONFIDENTIALITY LIMITS AND EXCEPTIONS

1. Normally, everything we discuss will be held confidential. Unless you provide authorization, I will not speak to or correspond with anyone about you. If you choose to break confidentiality in any way (i.e., sending me an e-mail, applying for insurance reimbursement, telling anyone about your therapy, text message me) I cannot control, or be held liable for the outcome.

2. **Exceptions to Confidentiality:** Texas law and professional ethics either mandate or permit therapists to break client confidentiality under certain circumstances. Some 'exceptions to confidentiality' include situations in which there is reasonable suspicion that any of the following has ever occurred or is occurring now:

- you or your child present a danger to self or others; including knowing transmission of AIDS/HIV and others communicably transmitted diseases.
- a child or dependent adult is the victim of emotional, sexual or physical abuse, neglect or unjustified mental suffering
- a dependent adult or person over the age of 65 years is the victim of physical abuse, emotional abuse, abandonment, forced isolation, fiduciary abuse, or neglect
- you experience sexual exploitation by a mental health professional or member of the clergy
- a fee dispute between you and this provider or negligence suit is brought by you against this provider, including filing a complaint with a licensing board or other state or federal regulatory authority;
- to support regulatory authorities compliance or investigatory responsibilities

- for operational purposes within my office and treatment consultations with other mental health professionals when deemed necessary by this provider.

**Note that the preceding is a sample, and not a complete list of exceptions to confidentiality. This will be outlined during our first session. FOR FURTHER INFORMATION PLEASE REVIEW THE NOTICE OF PRIVACY PRACTICES PAPERWORK PROVIDED TO YOU.

3. **Defamation:** By signing this intake authorization and consent form below you agree that you will not make defamatory comments about your therapist to others or post defamatory commentary about your therapist on any website or social media site. In the event that defamatory remarks about your therapist are made by you, or others acting in concert with you, you further consent by signing this intake and consent form below allowing your therapist to use confidential information necessary to rebut or defend against or prosecute claims for the defamation.

4. **Therapist's Incapacity or Death:** You acknowledge that, in the event your therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of your file and records. By signing this information and consent form below, you give consent to allow another licensed mental health professional selected by your therapist to take possession of your file and records and provide you with copies upon request, or to deliver them to a therapist of your choice. Your therapist will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional.

OFFICE ENVIRONMENT

Please do not make calls on your cell-phones in the waiting area. This may disrupt the therapy sessions occurring in the connecting offices.
G

LIMITS OF COMMUNICATION

1. Every effort will be made to assist you, especially during crisis. However, this provider does not provide 24 hour crisis or emergency therapy services. There may be times when contacting you won't be possible. Therefore you must agree to first call 911 or go to the nearest hospital Emergency Room for assistance, any time you suspect you are in crisis.

2. Calls are retrieved from my voice mail at (714) 679-6111 several times during the day (M-F) at random intervals. Phone calls are acceptable means of communication for scheduling purposes. Please note that while my voicemail system is confidential, it may not meet the State and Federal privacy guidelines or HIPAA encryption standards. Please use discretion when leaving messages. Please note that I am often not immediately available by phone and will not take calls while with a client. Reasonable effort will be made to return calls during normal business hours on the day it is received, weekends and holidays excluded. Messages left after hours or on weekends or holidays, or when counselor is out of office are normally returned the next business day.

3. Most email does not meet State and Federal privacy guidelines for sharing per-

sonal health information. Thus please use discretion when communicating with me by email. Any private needs or concerns would be best discussed in person or over the phone. Please also note I communicate by email for practical matters. Any therapy related issues will need to be discussed in your next session. Any electronic communication sent by you may be retained by this provider in your therapy record.

4. Correspondence sent by postal mail to this office is retrieved at random, and several days may go by before mail is retrieved. My office hours vary randomly from day to day, and normally no one is available to sign for deliveries.

5. At times, my other work settings does not permit me to receive or place telephone calls. Your 'Caller ID' or 'Call-Blocking' may also prevent my return calls. Please leave your phone number in your voice message.

6. If necessary, my voice-mail will provide the name and telephone number of a colleague who you can call for assistance when I am not available.

7. For a variety of reasons that we can discuss, I do not connect and correspond with current or former clients on social media websites. This includes Linkedin, Twitter, Facebook, Instagram and all other social networking sites.

8. **Appointment reminders** are sent through TherapyNotes.com. Whether a reminder is received or not, you are still held responsible for remembering your appointment time and day. Appointment information is considered to be "Protected Health Information" under HIPAA. By your signature below, you are authorizing that appointment information be transmitted through the email address you have indicated on the 'contact form' of your intake document. Please note that text, voicemail, direct email and fax messaging may not be encrypted to HIPAA standards.

TREATMENT TERMINATION

1. If at any time during the course of your treatment I determine I cannot continue, I will terminate treatment and explain why this is necessary. Ideally, therapy ends when we agree your treatment goals have been achieved. Additional conditions of termination include:

• You have the right to stop treatment at any time. If you make this choice, referrals to other therapists can be provided and you will be asked to attend a final 'termination' session.

• Professional ethics mandate that treatment continue only if it is reasonably clear

you are receiving benefit. If you are meeting with another individual therapist, you must first terminate treatment with that therapist before I can begin providing services. If you remain in therapy with someone else and this becomes apparent after we begin, I am ethically required to terminate your treatment. This does not apply to couples seeing me and also seeing an individual therapist nor individuals seeing me while also in couples therapy.

• Other legal or ethical circumstances may arise and compel me to terminate treatment. In these cases appropriate referral(s) will be offered. Also, I do not diagnose, treat, or advise on problems outside the recognized boundaries of my competencies.

• Other situations that warrant termination include: regularly becoming enraged or threatening during session; bringing a weapon onto the premises; persistent drug abuse; arriving under the influence of drugs or alcohol; disclosing illegal intentions or actions; multiple missed appointments. After a missed appointment, if you do not call to reschedule within 30 days, your therapist will accept this as your notice that you have terminated treatment and that you wish to no longer receive services and close your treatment file.

AUTHORIZATION AND CONSENT TO COMMENCE PSYCHOTHERAPY

Your signature below will verify that you have read (or that I have read to you) the information in this authorization and consent and that you asked questions

about anything you have not understood up to this point. By signing, you freely acknowledge your willingness to undergo treatment using psychotherapy methods, as I deem appropriate and in accordance with this 'Informed Consent and Authorization.'

You agree to enter into a professional business arrangement according to all business practices outlined in this agreement. You accept total financial responsibility for payment of all fees and services as described, regardless of your expectation of insurance coverage or any other 'third- party' payers.

You will also be authorizing and consenting to release me of any liability that directly or indirectly results from disclosure or exchange of any information covered in this agreement. This will include your consent and authorization to your therapist to share confidential information with all persons mandated or permitted by law, with the agency that referred you and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless your therapist for any departure from your right of confidentiality that may result.

At your request, a copy of this and any other document in your record that bears your signature will be provided.

Your therapist aims to provide services in a professional and ethical manner within accepted legal standards. If you are ever dissatisfied with your therapy, please discuss these concerns with your therapist. If they are not able to resolve these issues you may report complaints to the Texas State Board of Examiners of Professional Counselors, P.O. Box 141369 Austin, Texas 78714-1369.

Duty to Warn: In the event that your therapist reasonably believes that you are a danger, physically or emotionally, to yourself or another person, by signing this information, authorization and consent form below, you specifically consent and authorize your therapist to warn the person in danger and to contact any person in position to prevent harm to yourself or another person, in addition to medical and law enforcement personnel, and the persons you list as your emergency contact are also authorized for contact.

This information is to be provided at your request for use by said persons only to prevent harm to yourself or another person. This authorization shall expire upon the termination of your therapy with your therapist.

You acknowledge that you have the right to revoke this authorization in writing at any time to the extent your therapist has not already taken action. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices, that you have received and reviewed.

You acknowledge that you have been advised by your therapist of the potential of re-disclosure of your protected health information by the authorized recipients and that it will no longer be protected by the federal Privacy Rule.

You further acknowledge that the treatment provided to you by your therapist was conditioned on you providing this authorization.

_____ _____

Signature Today's Date