RESTORATION COUNSELING

heal connect enrich

THERAPIST-CLIENT SERVICE AGREEMENT

Welcome to Restoration Therapy. This agreement contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client 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. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this agreement and can be found at http://health.state.tn.us/HIPAA/index.htm, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information on or before the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our first session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Therapy is not easily described in general statements. It varies depending on the personalities of the Therapist and client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Therapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy 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. But there are no guarantees of what you will experience.

Our first session or few sessions will involve an evaluation of your needs and we will decide together whether we feel each of us is a good fit for the goals you hope to accomplish with therapy. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. 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. 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.

SOCIAL MEDIA AND EMAIL POLICY

This section outlines my policies related to the use of Social Media. As new technology develops and the Internet changes, I will update this section accordingly.

Friending: I do not accept friend requests from current or recent former clients on any social networking site. I believe that adding clients as friends on these sites can compromise client confidentiality and client's respective privacy. It may also blur the boundaries of the therapeutic relationship.

Email/Text: Email and texting is not completely secure or confidential. For those who choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. E-mails I receive from clients and former clients, along with any responses that are related to treatment and diagnosis may be printed out and kept in respective treatment records.

Current and former client e-mail information is always kept secure and not shared with third parties. Cancellations will not be accepted via text or email. You must speak with me directly via phone. While most of these communications will not be put into your medical record, if these communications contain anything other than scheduling matters, they will become a part of your medical file.

MEETINGS

Clients are asked to commit to weekly sessions. The length of therapy is always the client's decision. I normally conduct an evaluation that will last from 2 to 4 sessions. 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 therapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation by phone. For extenuating circumstances I reserve the right to judge on a case-by-case basis and can provide alternative means of therapy services on a limited basis (i.e. by phone).**

PROFESSIONAL FEES

My hourly fee is $125.00 and I provide a sliding fee scale as appropriate and available. In addition to weekly appointments, I charge this amount 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 five (5) minutes, 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. Because of the difficulty of legal involvement, I charge $200 per hour for preparation and attendance at any legal proceeding, including travel. I do have a sliding scale for clients who demonstrate severe financial need (not available for legal consultation) as available. Using the sliding scale, the fee is determined by total family income and number of dependents; I may request a copy of your most recent tax return or pay stubs to verify information provided. If you have a change in income for your household, it is your responsibility to let me know so that fees can be adjusted if needed. Your fee agreement with me is updated as needed. Cancellations, changes or rescheduling must be made 24 hours in advance. A charge of the regular fee will be made for the time reserved if you fail to give this notice or do not keep your appointment time. If there are extenuating circumstances I reserve the right to judge this on a case-by-case basis. Angela Landry accepts cash, check or card payments. If paying by card, the information is stored in an online secure payment processing database. This program attends to all HIPAA requirements.

CONTACTING ME

Due to my work schedule, I am not immediately available by telephone. While I am usually in my office between 9 AM and 5 PM Monday-Thursday, I will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by a confidential voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it or 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the Therapist, psychologist or psychiatrist on call. You can also call a Crisis Hotline at 1-800-784-2433 or for a minor you can call 800-273-TALK (8255). If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. If while I am gone and it is a non-emergency, leave me a voice message and I will get back to you when I return to the office. Cancellations will not be accepted via text or email. You must speak with me directly via phone.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a Therapist. 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. Your signature on this Agreement provides consent for those activities, as follows:

- If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

- As a therapist pursuing best practice, Angela Landry does consult with other qualified professionals, as needed, in order to offer the best services to her clients. All identifiable client information is concealed when consulting with other professionals.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the Therapist-client privilege law. I cannot provide any information without your written authorization, or a court order by a judge. I am not legally bound to respond to a subpoena but only a court order by a judge.
- 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 may be required to provide it for them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If a client files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

- If I have reason to believe or suspect that a child has been neglected or abused as deemed by TN state standards, the law requires that I file a report with the appropriate governmental agency, usually the Department of Children Services (DCS) or Child Protective Services (CPS). Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report to an agency designated by the Department of Human Resources, usually Adult Protective Services (APS). Once such a report is filed, I may be required to provide additional information.
- If I determine that a client presents a serious danger of violence to another or themselves, I may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client.

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.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis (if applicable), the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone.

Except in unusual circumstances that involve danger to yourself and others or makes reference to another person and I believe that access is reasonably likely to cause substantial harm to such other person or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or be 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. In most situations, I charge a copying fee of $3.00 per page (and for certain other expenses). If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) that I will discuss with you upon request.

With the above in mind, if you or another entity requests your records, I initially have the right to refuse release. If release is still requested the release of your information is a three-tiered process. First, you will receive a copy of your intake paperwork and a summary of treatment. If more information is still requested your file will go for consideration with my consultant(s). The HIPPA law does not require that I release all contents of your file so as to protect from the above stated circumstances. This consideration lasts for 14 days. At the end of this process, if it agreed upon by my consultant(s) and I to release your case file you will receive a copy. If it is not, we can discuss the reasoning why it was decided not to release your protected health information to yourself or a third party.

CLIENT RIGHTS

HIPPA provides you with several client 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, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Clients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or unless we agree otherwise. Because privacy in therapy is often crucial to successful progress, particularly with teenagers, it is my policy (sometimes) to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. 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.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested and as outlined in this document. If you desire to pay by credit card you will be charged a processing fee per use.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

While I understand your desire to use your insurance to pay for your therapy sessions, I do not accept insurance or speak with insurance companies for several reasons. You are welcome to submit receipts for reimbursement on your own. It is your responsibility to negotiate with your insurance carrier regarding any reimbursement from them.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. The document also serves as an acknowledgement that you have received the HIPPA notice form described above.

CLIENT: _____ DATE: _____

If younger than 17, please have a guardian sign below:

GUARDIAN: _____ DATE: _____

HIPPA DISCLOSURE

TENNESSEE NOTICE FORM

Notice of Counselor's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your Protected Health Information (PHI) for treatment, payment, and health care operations purposes with your consent.

"PHI" refers to information in your health record that could identify you.

"Treatment" is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

"Payment" is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility for coverage.

"Health Care Operations" are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

"Use" applies to activities within my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosure Requiring Authorization

I may use or disclose PHI for purposes of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes"* are notes I have made about our conversation during a private, group, joint, or family counseling sessions, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. "Psychotherapy notes" are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

You may revoke all such authorizations (or PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that information, or (2) if the authorization we obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may disclose PHI without your consent or authorization in the following circumstances:

Child Abuse. If I have reasonable cause to believe that a child has been abused, neglected, or exploited, I must report that belief to the appropriate authority.

Adult and Domestic Abuse. If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authorities.

Health Oversight Activities. If I am the subject of an inquiry by the Tennessee Board, I may be required to disclose protected health information regarding you in proceedings before the Board.

Judicial and Administrative Proceedings. If you are involved in a court proceeding and a request id=s made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release

information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety. If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.

Worker's Compensation. I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. **Patient's Rights and Psychologist's Duties**.

Patient's Rights:

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations. You have the right to request confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your written request, I will send your bills to another address.)

Right to Inspect and Copy. You have the right to inspect and obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and the denial process.

Right to Amend. You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting. You have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy. You have the right to obtain a paper copy of the notice from me on request, even if you have agreed to receive the notice electronically..

Counselor's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, I am required to abide by the terms currently in effect.

If I revised my policies and procedures, I will provide you with a revised notice by mail or at your next appointment.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me for further information.

You may also send a written complaint to the US Department of Health and Human Services, Office of Civil Rights, (www.hhs.gov/ocr/hipaa).

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go in effect April 15, 2003. I will not limit the uses or disclosures that I will make.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or at your next appointment.

RESTORATION COUNSELING

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ADULT INTAKE FORM

The following form, which will become a part of your confidential record, will enable us to gain a quicker understanding of you and the problem for which you seek help. Please answer each question as completely and carefully as you can. You may use the back of any page for additional comments.

YOU HAVE PERMISSION TO LEAVE PHONE MESSAGES AND SEND MAIL TO:

Client: _____ Birthdate:____/_____/_____ Age:_____ Sex: M / F

Present Address:_____
Street City State/Zip

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Email (s):_____ SSN:_____

Preferred Method of Contact? ❑ Email ❑ Phone Ethnicity (optional) : _____

Marital Status (check one): ❑ Single ❑ Married ❑ Divorced ❑ Separated Have you been married more than once? ❑ Yes ❑ No

Spouse's Name: _____ Occupation: _____

Your Employer: _____ Occupation: _____

Employers Phone: _____ Total hours/week: _____ Approximate Gross Income: _____

Have you been in the military: ❑ Yes ❑ No If yes, what branch_____ ❑ Active ❑ Inactive

Religious Affiliation: _____ ❑ Active ❑ Inactive

Referred by: _____

May I contact this person to thank them for the referral? ❑ Yes ❑ No

Person to notify in case of an emergency: _____

Phone Number: _____ Relationship to Client: _____

Address: _____
Street City State/Zip

Have you ever experienced any severe psychological trauma? ❑ Yes ❑ No If yes, please describe:

_____

_____

A. Your Education and Training

Dates From	To	Schools	Major	Did you graduate?	Degree

B. Family-of-origin History

	Name	Current age (or at death)	Illness (or cause of death, if deceased)	Education	Occupation
Father					
Mother					
Stepparent					
Brothers					
Sisters					

C. Significant Marital & Non-Marital Relationships

	Name of person	Person's age when started	Your age when started	Your age when ended	Reasons for ending
First					
Second					
Third					

D. Children

(Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Current age	Sex	Grade	Adjustment problems?	P?

Have you ever had counseling before? ❑ Yes ❑ No

If yes, please describe and list name of person(s) _____

_____

Have any of your family had counseling before? ❑ Yes ❑ No

If yes, for what? _____

_____

Do you use alcohol or drugs? ❑ Yes ❑ No

If yes, please describe frequency and type: _____

_____

Any history of drug or alcohol abuse in your family? ❑ Yes ❑ No

If yes, please describe: _____

Anything important that happened in your childhood that you think has affected your life? ❑ Yes ❑ No

If yes, please describe: _____

Have you ever had any physical problem that you feel has affected your life? ❑ Yes ❑ No

If yes, please describe: _____

What medications are you presently taking? *(please include name and dosage to the best of your ability)*:

Have you ever experienced any sexual difficulties? ❑ Yes ❑ No

If yes, please describe: _____

Are you a registered sex offender? ❑ Yes ❑ No

Problem Areas:

In the following list, place a check mark next to each item that identifies an area of concern to you. **Place two checks by those items that are most important.** (You may add written comments on back of sheet)

_____ Abuse
_____ Anger/Temper
_____ Anxiety/Phobia
_____ Confusion
_____ Education
_____ Family Problems
_____ Fearfulness
_____ Financial Problems
_____ Guilt
_____ Marital Problems
_____ Physical Problems
_____ Problems with social relationships
_____ Problems with Children
_____ Other: _____

_____ Problems with eating
_____ Religious/Spiritual Concerns
_____ Sexual Concerns
_____ Stress
_____ Trouble Concentrating
_____ Trouble Making Decisions
_____ Trouble with Memory
_____ Unhappy most of the time
_____ Use of alcohol/drugs
_____ Work
_____ Worry
_____ Losing Track of Time
_____ Thoughts of Suicide

In your own words, briefly describe the main problem which prompted you to seek counseling at this time.

Have there been times when the problem got better or disappeared? ❑ Yes ❑ No

If so, when? _____

What do you think helped? _____

Were there times when the problem was especially bad? ❑ Yes ❑ No

If so, when? _____

What made it bad? _____

Are there other people who play a major role in causing your problems? ❑ Yes ❑ No

Explain briefly: _____

_____

Are there other people who play a major role in helping you to cope with your problems? ❑ Yes ❑ No

If yes, explain briefly: _____

_____

Please state what you have done to solve the problems/issues that bring you in for counseling:_____

_____

Is there anything else which you believe it might be important for your counselor to know at this time?

_____

_____

What are you wanting from counseling? _____

_____

Your goals? _____

_____

RESPONSIBILITY FOR PAYMENT

I understand that all services are rendered and charged to me and not to a third party or an insurance company. I understand that I am responsible for paying for all services including extended sessions, telephone calls, preparation of reports, and any unkept appointments. I understand that I am responsible for paying full charges on all appointments that are unkept, rescheduled, or cancelled with less that 24 hours advance notice to Restoration Counseling.
I understand and agree that I will pay all fees at the time services are rendered or billed to me. I understand that Angela Landry, LMFT cannot accept responsibility for collecting or negotiating a settlement on an insurance claim. I hereby accept full and complete responsibility for all debts and obligations during the course of the above named client's evaluation and/or treatment. For the purpose of collecting debts, I understand and agree that the above information will be released to a collection agency in the event that I do not pay my account within thirty (30) days of services. I authorize all of the above information, including last date of service and total amount of debt, to be released for the purpose of collecting the debt.

I have read the attached Information sheet and voluntarily request counseling services through Restoration Counseling in accord with terms described on the information sheet.

_____

Client's Signature Date

PLEASE SUBMIT PAYMENT WITH THIS FORM PRIOR TO THE FIRST SESSION

If you indicated that I may send a thank you to the person who referred you, please provide a referral name and any contact information you may have below:

_____

_____