CONNECTICUT CENTER FOR NATURAL HEALTH

Service Agreement and TherapyTreatment Consent

Welcome to The Connecticut Center For Natural Health! The decision to being in therapy can be a difficult one. By making this decision, you have made a commitment to your emotional well-being and to improving your relationships with others. 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 federal law that provides 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 and Office Policies

Payment of Fees

Connecticut law requires that all fee(s) are established and agreed to before we can begin. This section clarifies all fees, and defines your financial responsibilities.

If you choose to use your insurance for payment, any co-pays or fees will be discussed prior to your first session and are payable by cash, check or charge at the time of service. If your insurance company is being billed, I will make appropriate efforts to obtain payment. However, you as the client are ultimately responsible for any outstanding charges that are not covered. By signing this agreement, you take responsibility for outstanding balances.

My usual and customary fee for your first appointment, described as the “diagnostic assessment” or “intake”, is $150.00. Individual sessions (where only the identified client is present) are charged at $100.00 per session. Couples and/or family sessions (where client plus spouse/partner or additional family member is present) are charged at $150.00 per session. Individual, couple, and family sessions are 50 minutes in length from the scheduled start of the appointment, regardless of your arrival time. It is important for us to end on time so I am available to document our session, review records and/or make collateral phone calls on your behalf. I am unable to extend sessions due to other scheduled appointments. The frequency of sessions depends on clinical need and can be discussed at your first session and re-evaluated at subsequent sessions. I require that you maintain a treatment schedule of at least one appointment per month to keep your case active.

Occasionally, clients may request written reports or treatment summaries to be provided to other professionals or providers. This will only be done at your written request. Insurance carriers do not pay for such services and therefore, my charge for any services provided outside of the usual and customary is $90.00 per hour. Any requests for letters regarding clinical treatment or copies of records will be completed in a timely manner, no later than 30 days from the date the written request is received. The fee for copies of records will be $.60 per page. Same day requests will not be honored. When you decide to withdraw from treatment, or upon successful completion of treatment, a discharge summary will be generated. You may obtain this free of charge by written request.

I will not testify in court. By choosing to work with me as your mental health provider, you acknowledge and understand that I will not participate in any court proceedings.

Attendance

If you need to cancel an appointment, please provide the office with 24-hours notice. Appointments cancelled with less than 24-hour's notice or appointments in which you do not show will result in a missed appointment charge of $50. This will NOT be billed to your insurance, and will be payable by you at the next scheduled session. While emergencies can arise that may lead to scheduling changes or a possible no show to a scheduled session, it is important you notify me as soon as possible if you are unable to attend. In order to ensure that you receive the best results in treatment, it is important that you participate in the therapeutic intervention by attending all scheduled sessions. Three or more appointments missed without 24-hours notice in a 90-day period may result in the discharge of your case, and I will refer you to a provider you may find more suitable to your clinical and scheduling needs.

Clinical topics and issues will not be discussed through text messaging or email. If you have clinical needs or concerns, please schedule an appointment. Text messaging and email communication will be limited to confirming and/or cancelling appointments only. Please note that messages are checked once daily and I will do my best to return your call in a timely manner, typically within 24-48 hours (unless the message is left on a Friday or on a holiday). If you are experiencing a clinical emergency, please utilize 211 for mobile outreach services, call 911 or go to your closest emergency department. I do not offer on-call or after hours services.

In the event of inclement weather, the office may be closed for appointments. I will notify you as soon as closure is indicated.

Client Rights & Responsibilities

The therapeutic relationship is a collaborative and voluntary partnership. If at any time you feel treatment lacks direction or is not meeting your expectations, I would ask that you begin a dialogue so we can address your concerns together. You have the right to be treated without regard to race, religion, sex, age, national origin, marital status, sexual orientation, and mental or physical disability. Additionally, I ask that you do not attend sessions under the influence of drugs or alcohol, or your session will be rescheduled. Persistent drug abuse during session may result in termination of treatment. Furthermore, abusive language, threatening, or physical aggression will not be permitted during session and may also warrant termination if this behavior becomes a regular occurrence. Under no circumstances will bringing a weapon on the premises be tolerated. All expectations noted above reflect my highest regard for mutual respect, safety and personal dignity.

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 continues only if it is reasonably clear you are receiving benefit.

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

Risks Associated with Psychotherapy

The therapeutic process can be one of tremendous personal emotional growth. It involves an investment both on the part of the client and the therapist and a commitment to the process. Psychotherapy also has inherent risks. Some of these risks to you are:

- There may be times during your course of treatment that you are faced with difficult emotions and/or painful memories. It is possible that this process will bring up resentment and uncomfortable feelings in the therapy room. It is important to talk about this with me to let me know what is going on for you through our meetings.

- It is important to remember also that this process is *voluntary*. You may withdraw from treatment at any time.

- Although therapy begins with the hope that your life and relationship(s) improve, there is no guarantee that this will occur.

Limits to Confidentiality

The confidentiality of your records is highly valued. The law protects the privacy of communications between a client and therapist, although some situations are excluded by law. 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.

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, use an analog cell-phone) I cannot control, or be held liable for the outcome.

Limits to preserving confidentiality include the following:

- 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.

- 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.

- 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.

- If such a situation arises, I will make a reasonable effort to fully discuss it with you before taking any action and will limit my disclosure to what is necessary.

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. I UNDERSTAND I HAVE THE RIGHT TO END TREATMENT AT ANY TIME.

_____ _____

CLIENT SIGNATURE **DATE**

_____ _____

THERAPIST SIGNATURE **DATE**

CONNECTICUT CENTER FOR NATURAL HEALTH

Consent for Purposes of Treatment, Payment and Healthcare Operations

In this document, "I", "me" and "my" refers to the client, and "Practitioner" refers to Sean Macauley, LMFT.

I consent to the use or disclosure of my protected health information by Practitioner for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Practitioner. I understand that analysis, diagnosis or treatment of me by Practitioner may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Practitioner is not required to agree to the restrictions that I may request. However, if Practitioner agrees to a restriction that I request, the restriction is binding on the Practitioner.

I have the right to revoke this consent, in writing, at any time, except to the extent that Practitioner has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Practitioner and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Practitioner. This Notice of Privacy Practices also describes my rights and duties of the Practitioner with respect to my protected health information.

Practitioner reserves the right change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Practitioner and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Client Signature/Personal Representative Print Name of Client

_____ _____

Describe Personal Representative's Authority Date