Client Contract

Practice Policies and Procedures

Welcome to our practice. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

Meetings

Intake evaluations begin with a 90 minute session (unless an alternative time is agreed upon by both parties) in addition, this information gathering will continue over several sessions. During this time, we can both decide whether the treating therapist with Cohn Counseling is the best person to provide the services you (or your child) needs in order to meet your treatment goals. Counseling sessions are generally scheduled once a week for 45-60 minutes depending on your needs, preference, and budget.

Contacting Your Therapist

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, please leave a message on my voice mail. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are unable to reach me and feel that you can't wait for me to return your call, contact your physician or the nearest emergency room and ask for the psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary, and that information will be on my voice mail. I only use email for setting up appointment times or contacting a client who has missed an appointment. I do not use it for discussion of clinical issues.

Emailing your Therapist

This statement is to inform you that email does not meet the privacy standard implemented by **HIPPA** and if you choose to email you are accepting the risk that the communication in which you engage in electronically is not protected. Your therapist will make reasonable efforts to keep this communication confidential, however the client takes the burden of risk if they choose to engage in this form of communication.

____ Accept the Risk
____ Deny the use of Email

_____ _____
Signature of Guardian or Client Date

_____ _____
Signature of Therapist Date

Texting your Therapist

Texting will only be a means of communication in discussing scheduling appointments, any other communication will require a session be scheduled with your therapist.

Duration of Treatment

Most clients see their therapist once a week for six months, but the length of treatment is unique in each case. The process of ending therapy, called "termination," can be a very valuable part of our work. Stopping therapy should not be done casually, although either of us may decide to end it if we believe it is in your best interest. If you wish to stop therapy at any time, I ask that you agree to meet then for at least one more session to review our work together. We will reflect upon our goals, the work we have done, any future work that needs to be done, and our choices.

INFORMED CONSENT- HIPPA

In the event I feel I need to consult another professional in order to provide for your child's needs, I will do so, but only in a professional manner. Your identities will be kept anonymous. I will use the same guidelines as above to maintain confidentiality. Tell me if this is a concern.

This information is being provided as required by the Health Insurance Portability and Accountability Act.

NOTICE OF PRIVACY PRACTICES Effective April 14, 2003

This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I have a duty to maintain privacy of your health information and to provide you with this notice. You will be asked to sign a Consent Form. Once you have signed the Consent Form, I may use or disclose your Protected Health Information for purposes of diagnosis, treatment, obtaining payment, or to conduct healthcare operations. For example, if you choose to use insurance, to receive payment I must provide information about you to your insurance company.

Other permitted and required uses and disclosures that may be made without your consent, authorization or opportunity to object:

Abuse or Neglect: If I suspect abuse or neglect of a child or elder, I am mandated to make a report to the appropriate public authorities.

Danger: If I suspect you are in imminent danger of harming yourself or someone else, I am mandated to make a report to the person at risk and to the public authorities.

Legal Proceedings: I may disclose Protected Health Information in response to a court order or subpoena or in certain other legal proceedings.

You have the following rights regarding health information I maintain about you:

Right to Inspect and Copy: You have the right to inspect and request copies of information that may be used to make decisions about your care. Usually this includes demographic and billing records but does not include psychotherapy notes. To inspect and/or receive copies of information, you must submit a request in writing. If you request a copy of information, I may charge a fee for the cost of copying, mailing or other supplies associated with your request. I must respond to your request within fifteen days of receipt.

Right to Amend: If you feel that health information about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept by me. Your request for amendment must be in writing and must provide a reason supporting your request.

Right to an Accounting of Disclosures: You have the right to request an Accounting of Disclosures I have made of information about you. You must submit your request in writing to the above address. Your request must state a time period for the disclosures, which may not be longer than six years and may not include dates before April 14, 2003.

Right to Request Restriction on Uses and Disclosures: You may request that disclosure of confidential information be limited. If I am unable to agree to that restriction, we can discuss other options, such as referral to another counselor.

Right to Limit Reception of Confidential Information: For example, you may request that I only contact you at a certain telephone number or address. You do not have to give a reason for your request.

Right to a paper copy of this Notice.

Other uses and disclosures of Protected Health Information and any disclosure of Psychotherapy Notes will be made only with your written authorization. After such authorization is given, you may revoke that authorization at any time. This Notice may be amended as needed to comply with federal, state and professional requirements.

If you believe your privacy rights have been violated, please let me know either in writing or by talking with me. Such a complaint will not result in any retaliation by me. You may also file a complaint with the Secretary of the US Department of Health and Human Services.

I certify that I have read and accept the included brochure about my psychologist's policies and procedures. I understand that it is my responsibility to ask any questions that I may have of my clinician before signing. I understand that we will begin with an assessment of my family's needs and that neither the psychologist nor I are under any obligation to continue with treatment from that point. I further understand that mental health is not an exact science and that no guarantee can be made as to the result or success of my treatment. I understand that treatment often involves making significant changes and that every change potentially has both positive and negative effects. I understand the potential benefits and risks involved in seeking mental health treatment and am willing to proceed at this time. I understand that I can discuss any questions or concerns that I have with my clinician at any point.

_____ Signature of Client

_____Date

_____ Signature of Custodial Parent / Guardian

_____Date

_____ Printed Name of Client

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me) and understand the information for clients and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do herby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or any procedures provided by this therapist.

I am aware that I may stop by treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (for example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If i do not cancel and do not show up, I will be charged for that appointment's service fee in total. I am aware that if I have an outstanding balance of $600 or more, or services have been unpaid for more than 60 days a third-party collections agency may be given information about the type(s), cost(s), dates(s), and providers of any services or treatments I receive.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), dates(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of Client (or person acting for client) Date

_____ _____

Printed name Date

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to five informed and willing consent.

_____ _____

Signature of Therapist Date

_____ Copy accepted by client _____ Copy kept by therapist

This is strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.