Mindful Balance
Therapy Center

Consent to Treatment

Welcome to my practice. I am governed by various laws and regulations and by the code of ethics of my profession. The ethics code requires that I make you aware of specific office policies and how these procedures may impact you. This document contains important information about my professional services and business policies. Please read it carefully. When you sign this document, it will represent an agreement between us.

The following describes the conditions under which treatment will be provided to:

Name____ Date of Birth ________________

Counseling Services:
The process of psychotherapy can vary greatly depending upon many factors, including the personalities of the therapist and the client, the types of problems that are being discussed in therapy, and the motivation of the client. Psychotherapy calls for a very active effort on your part – in order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing difficult aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. Go at your own pace and please communicate with me how the process is going as it unfolds. Although negative emotions can arise, psychotherapy has also been shown to have benefits for many people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Since there are so many factors related to the outcome of therapy, there are no guarantees of what you will experience.

My office hours vary week to week, and I am often not immediately available by telephone. I do not provide emergency services. If you are in a situation that threatens your safety or the safety of others, call 911 or go to your local emergency room.

My Qualifications:
I have Master's degree in Marriage and Family Therapy from Antioch University New England and am a Certified LifeForce Yoga Practitioner. As a Licensed Marriage and Family Therapist (LMFT), I work with individuals, couples and families from a systemic perspective. I strive to understand each client's personal story, including family history, relationship development, and social and economic factors which can have a great impact upon current life situation. As a Certified LifeForce Yoga Practitioner (LFYP-1), I teach mindfulness based techniques to clients, including breathing techniques and gentle movement which may provide a way to work with and manage mood. I have experience working with individuals and couples with a wide variety of life circumstances, including those with diagnoses such as anxiety or depression, couples processing through a recent affair or other major stressors, and those with trauma histories, to name just a few.

Professional Regulations:
My practice is governed by the Rules of the New Hampshire Board of Mental Health Practice. It is unprofessional for me to violate those rules. A copy of the rules may be obtained from the Board or online at http://www.gencourt.state.nh.us/rules/state_agencies/mhp.html.

My practice is also subject to the Client Bill of Rights, the purpose of which is to protect the rights and enhance the wellbeing of clients, by informing them of key aspects of the clinical relationship. A copy of the "The Mental Health Bill of Rights" can be found online at http://www.nh.gov/mhpb/documents/bill_of_rights.pdf. A copy is also posted in my office.

Fee Agreement:
Our sessions are 45-55 minutes in duration, depending upon allowable benefits by your insurance company, if applicable. My fee for each session is $130.00. Full payment is due at time of service. If you have health insurance, it is your responsibility to contact your insurance provider prior to your first session to confirm that you have coverage for outpatient mental health services at my office and determine how many sessions will be covered. If there is any co-pay associated with your insurance plan, full co-pay amount is due at time of service. Please give a minimum 24 hours notice if you need to cancel your appointment. There is a $40.00 fee for missed appointments that are cancelled with less than 24 hours notice, except in the case of a true emergency.

At times, services may be more complex. For example, the need for me to submit a mandated report regarding potential abuse or neglect or the need for me to manage maladaptive communication that complicates care delivery. In such cases, there is a nominal fee of $10.00 per instance.

If for any reason you are unable to pay your fee and arrangements for payment have not been agreed upon, the therapist has the option of using legal means to secure payment. If such legal action is necessary, the therapist will only release to the collection agency the client name, identifying information (such as phone number, address, and social security number), nature of services and amount due. If I am asked to take part in any legal proceeding on behalf of a client or an action related to a client, the fee for any and all time participating in these actions is $150 per hour for all time spent, including, but not limited to, time preparing a treatment summary, report writing, trial preparation, travel time, and actual participation. The charge will be for a minimum of four hours to account for the rescheduling of a half-days worth of client sessions. These charges are not covered by your insurance.

Client Responsibilities:
I ask that you return phone calls and maintain scheduled appointments. If you miss multiple appointments, do not give the required notice for missed appointments, and/or you may be better served in an alternate therapeutic setting, services may be terminated or suspended. You should ask questions about anything you do not understand and tell me if you have concerns about any aspect of treatment. Carefully read any papers you are asked to sign and ask for help when you need it.

Confidentiality:
In general, the privacy of all communications between a client and a Marriage and Family Therapist is protected by law, and I can only release information about your treatment to others with your written permission. But there are a few exceptions. Disclosure may be required by a court order. There are also some situations in which I am legally obligated to take action to protect others from harm. If I believe a client is threatening serious bodily harm to themselves or another, I am required to take protective actions.

Notice of Privacy Practices:
Medical Information includes personal health information, protected health information, and any health information, whether oral or in recorded form, that is created by the therapist, health plan, or others that relates to the past, present, or future physical or mental health or condition of the client, the provision of health care to the client, or the past, present or future payment for providing health care to the client. As a mental health care provider, I create and maintain treatment records that contain individually identifiable health information about you. This notice concerns the privacy and confidentiality of those records and the information in those records.

Federal privacy rules allow health care providers to use or disclose the patient's personal health information, without the patient's written authorization, to carry out the health care provider's payment or health care operations. Disclosure for payment purposes would be disclosure to your health insurance provider if necessary to determine whether or not payment is warranted under the terms of your policy or contract. An example of a disclosure for health care operations would be if your health plan decided to audit my practice in order to review my performance, or to detect possible fraud or abuse, your mental health records may be disclosed for those purposes.

Other uses and disclosures without your authorization would include disclosures compelled by 1) a court order; 2) by a board, commission or administrative agency for purposes of adjudication; 3) a subpoena for mental health records; 4) by an arbitration panel when arbitration is lawfully requested by either party; 5) by a search warrant lawfully issued by a governmental law enforcement agency; 6) by the patient or the patient's representative pursuant to local or federal law; 7) by local law governing abuse, neglect or domestic violence; 8) if permitted by the fact that you are a danger to yourself or to another person or property of others; 9) by the fact that you tell me of a serious threat of physical violence to be committed by you against a reasonably identifiable victim or victims; 10) if in the event of your death to the coroner in order to determine the cause of your death; 11) to a health oversight agency for oversight activities authorized by law, including, but not limited to, audits, criminal or civil investigations, or licensure or disciplinary actions, e.g., The New Hampshire Board of Mental Health, which issues licenses to Marriage and Family Therapists, is an example of a health oversight agency; 12) by the U.S. Secretary of Health and Human Services to investigate or determine my compliance with privacy requirements under the federal regulations; and/or 13) if disclosure is otherwise specifically required by law.

Other uses and disclosures will generally be made only with your written authorization, even though federal privacy regulations or state law may allow additional uses or disclosures without your written authorization. Such written authorization shall be limited in scope and you may revoke your written authorization at any time, provided that the revocation is in writing and except to the extent that I have taken action in reliance on your written authorization.

<u>Your Rights Regarding Protected Health Information</u>:
You have a right to request restrictions on certain uses and disclosures of protected health information; however I am not required to agree to your requested restriction. If I do agree, I will maintain a written record of the agreed upon restriction. You have the right to receive confidential communications of protected health information from me by alternative means or at alternative locations. You have the right to inspect and copy protected health information about you by making a specific request to do so in writing. I am permitted to deny access for specified reasons, for example, you do not have this right of access with respect to my "psychotherapy notes". You have the right to amend protected health information in my records by making a request to do so in a writing that provides a reason to support the amendment. You also have the right to provide me with a written addendum with respect to any item or statement in your records that you believe to be incorrect or incomplete and to have the addendum become part of your record, subject to limitations.

You have the right to receive an accounting from me of the disclosures of protected health information made by me in the six years prior to the date on which the accounting is requested. As with other rights, this right is not absolute. I am permitted to deny this request for specified reasons. You have the right to obtain a paper copy of this notice from me upon request.

<u>Communication by Email, Text Message, and Other Non-Secure Means:</u>
It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with me, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with me
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want accessing these communications, please talk with me about ways to keep your communications safe and confidential.

<u>Authorization for Transmission of Protected Health Information by Non-Secure Means:</u>
I, ______________________________, authorize Allison Carey, LMFT, LFYP-1 to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of meetings or other appointments

- Information related to billing and payment
- Other information that is beneficial to the treatment process, such as a recommendation for a community support

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. This authorization will terminate when my case is closed with Allison Carey. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time by providing Allison Carey with a written request to terminate.

_______________________________________ ____________________

Signature Date

<u>My Duties</u>:

I am required by law to maintain the privacy and confidentiality of your personal health information. This notice is intended to let you know of my legal duties, your rights, and my privacy practices with respect to such information. I am required to abide by the terms of the notice currently in effect. I reserve the right to change the terms of this notice and/or my privacy practices and to make the changes effective for all protected health information that I maintain, even if it was created or received prior to the effective date of the notice of the revision and I will post the revised notice in a clear and prominent location. As the Privacy Officer of this practice, I have a duty to develop, implement and adopt clear privacy policies and procedures for my practice and I have done so. I am the individual who is responsible for assuring that these privacy policies and procedures are followed by me and by any of my employees.

Patient records are kept secure so that they are not readily available to those who do not need them. You may contact me and the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated by me or any of my employees. My telephone number is 603-903-1414. I will not retaliate against you in any way for filing a complaint with me or with the Secretary. Complaints to the Secretary must be filed in writing and can be sent to the NH Department of Health and Human Services, 129 Pleasant St., Concord, NH 03301-3852. If you have any questions about this Notice, please feel free to contact me.

<u>Outside Contact</u>:

Respecting your preferences for privacy, we will discuss how we shall handle contact by phone or contact outside the therapy context, if we happen to run into each other in public.

<u>Informed Consent to Treatment:</u>

Release of Information

I, _______________________________________, understand that all information about my treatment, or that of my minor child, will be confidential unless I voluntarily agree to its release to an agency or individual. Exceptions have been discussed in the Notice of Privacy Practices section above.

Authorization to Release Information to Insurance Companies

I authorize my insurance company or other agents paying for my treatment to receive information regarding my mental health or substance use treatment for the purposes of quality assurance monitoring, utilization review and payment of claims. I may revoke this consent at any time by notifying my treatment provider in writing. I understand that my insurance company may require access to information regarding my treatment in order to process payment of treatment services.

Couples, Family and Group Counseling

I understand that information from couples, family, and group counseling will not be disclosed outside of the treatment context without a written authorization from each individual competent to execute a waiver.

Minor Children

I understand that if a minor child is seeking treatment, by signing this Consent to Treatment I am attesting that I have the right to authorize such treatment for the minor child. In the case of divorced or separated parents, either or both parents may consent to treatment except in those cases where the parenting plan specifies which parent has the right to obtain

psychological care for the child. I understand that if a minor child is in treatment, that treatment information is available during treatment or in the future, to either or both parents unless the parenting plan states otherwise. Treatment information concerning the minor child may also be released to a third party, by authority of a court order, or when otherwise expressly required by law.

If you are involved in a divorce or custody litigation, you need to understand that my role as a therapist is not to make recommendations for the court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in the litigation. By signing this document, you agree not to call me as a witness in any such litigation. Only court appointed experts, investigators, or evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans.

Suspension/Termination of Services

I understand that failure to meet my responsibilities as a client (as outlined in Clients Rights and Responsibilities) may result in suspension and/or termination of services. I understand that other causes for suspension and/or termination may apply and, if so, I will be notified in writing that services have been suspended or terminated. I understand that services will be terminated if I indicate that I no longer wish to receive services, or if I have not had contact with the therapist for a period of 90 days.

Notice of Privacy Practices

I acknowledge that I have read the Notice of Privacy Practices Section contained herein.

Case Consultations and Supervision

Additionally, I understand that in order to provide excellence in clinical services and in accordance with accepted professional behavior, Allison Carey participates in case consultation and supervision with other local therapists. Every effort is made to protect identities.

_________________________ ____________________ ___________________________________

Signature Date Printed Name

I am authorized to sign this document as: ☐ Client ☐ Parent ☐ Guardian ☐ Other ______________________