

PSYCHOLOGY SUPPORT CENTER Support & Empower for Success

Do you need assistance with Reading? _____ Writing? _____
IF SO, PLEASE NOTIFY A STAFF PERSON AT THIS TIME TO RECEIVE ASSISTANCE.

Please be sure to read each section carefully.

Therapy Agreement, Policies & Consent

Part I: Confidentiality

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, *EXCEPT* for the following limitation:

- **Child Abuse** – Child abuse and/or neglect, which include but are not limited domestic violence in the presence of a child, child on child sexual acting out/abuse, etc. (Florida statute 39.201). If you reveal information relative to child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse** – Vulnerable adult abuse or neglect (Florida statute 415.1034). If you reveal information vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm** – Threats, plan or attempts to harm oneself – I am permitted under such instances to take steps to protect your safety which may include the disclosure of confidential information. (Florida statute 491.0147 and chapter 394).
- **Harm to Others** – Threats regarding harm to another person (Florida statute 491.0147). If you threaten bodily harm or death to another person, I am permitted by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas** – If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone and send you an email or letter (if I cannot get in touch with you by phone). If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Court Ordered Therapy** – If you are in therapy ordered by the court and the court requests records or documentation of your participation in services, the information/documentation that will be discussed/sent on your behalf will be discussed with you prior to information being sent to the court.
- **Written Request** – Your specified request, in writing, to disclose information regarding your psychotherapy to you or to a third party. In case of notes documenting or analyzing the contents of conversation during a private counseling session (“process notes”), I reserve the right to provide to you or the authorized third party a report of examination or treatment in lieu of copies of the actual records, unless the third party is a treating psychotherapist (Florida Statute 456.057 and HIPPA Privacy Rule). If therapy sessions involve more than 1 party, ALL parties over the age of 18 MUST consent to release of requested information prior to information being released.
- **Fee Disputes** – In the case of a credit card dispute, I reserve the right to provide the needed and adequate documentation i.e. your signature on the “Therapy Agreements and Consent” that covers the cancellation policy

to your bank or credit card company should you dispute a charge that you are financially responsible for. If you have a financial balance, you will be sent a bill to the home address on the intake form unless you advise me otherwise.

- **Couples Counseling & “No Secret” Policy** – When working with couples, all laws of confidentiality exist. I request that no separate party of the couple attempt to triangulate me into keeping a “secret” that is detrimental to the goal of therapy for the couple. If one party of the couple requests that I keep a “secret” in confidence, I may choose to end the therapy and give you referrals for other therapists as our work and your goals then become counter-productive.
- **Dual Relationships & Public** – My relationship with you is strictly professional. In order to preserve this relationship, it is imperative that we do not have any relationship outside the counseling relationship such as friendship, business, or social relationship. If we have contact in a public setting, I will not acknowledge you in any way that would jeopardize your confidentiality. Should you choose to acknowledge me, I may not be able to protect your confidentiality.
- **Social Media** – If you choose to connect with me on any of my professional (not personal) social media outlets such as Facebook, LinkedIn, Pinterest, Instagram, or Twitter, you do so at your own risk. I will do my best to protect your identity. However, if you choose to comment on my pages or posts, you do so at your own risk and I cannot be held liable if someone identifies you as a client.
- **Electronic Communication** – Email offers an easy and convenient way for therapist and client to communicate, but can also introduce unique challenges into the therapist-client relationship. Below are some guidelines for contacting me using email. Do not use email for emergencies. If it’s an emergency, consult with an emergency room. Email is not a substitute for seeing me. If you think that you might need to be seen, please call and book an appointment. Emails should not be used to communicate sensitive medical or mental health information. Email is not confidential. Be aware that if you send emails from your work, your employer has a legal right to read your email. Email is a part of your record. Further, texting also introduces some of the same challenges. Like email, it is not a substitute for seeing me or making an appointment. Texting is not confidential. Because phones can be lost or stolen, it is imperative that you do not communicate information of a sensitive nature over a text. Further, I cannot know the person who is texting is actually you, rather than another person who has possession of your phone.
- **Sessions Outside the Office** – from time to time, the people we work with would like to meet in an alternate location i.e. their home, in public, or somewhere more conducive for them. We are more than happy to accommodate your request, but please know that you may be taking a risk regarding your confidentiality. I cannot fully protect your confidentiality if we meet in a location other than my office.

Part II: Therapeutic Process

Benefits/Outcomes: Participating in therapy can result in numerous benefits, including improving intrapersonal and interpersonal relationships, resolving the concerns that led you to therapy. Therapy will seek to meet goals established by all persons involved, usually revolving around a specific complaint(s). A major benefit that may be gained from participating in therapy includes a reduction in distress and a better ability to handle or cope with personal, relational, family, work, and other problems as well as stress. Another possible benefit may be a greater understanding of personal and relational goals and values; this may lead to greater maturity and happiness as an individual and increased relational harmony. Other benefits relate to the probable outcomes resulting from resolving specific concerns brought to therapy. I will do my best to assess progress on a regular basis and solicit your feedback regarding the therapeutic process to help provide you with the most effective therapeutic services. I can make no guarantee as to the ultimate outcome of therapy.

Expectations: Work outside of the counseling sessions is an essential aspect of change. I may assign tasks between sessions related to your goals. My commitment is to work as efficiently as possible, but at the same time, therapy may move more slowly than you anticipated. We will collaborate to identify your therapeutic goals and will periodically review your progress toward them.

Risks: In working to achieve these potential benefits, the therapeutic process requires that actions be made to change and may involve experiencing discomfort. Therapeutically resolving unpleasant events and relationship patterns may arouse intense, unexpected feelings. Seeking to resolve problems can similarly lead to discomfort as well as relational

changes that may not originally be intended. We will work together for a desirable outcome; however, there is a possibility that the goal of therapy may not be met. We will review your progress at regular intervals and modify our treatment plan as needed.

Structure of Therapy:

- **Intake Phase** – During this phase we will discuss the process, structure, policies and procedures of therapy. This occurs during the first session. We will need to spend some time (usually brief) exploring your experiences both surrounding the presenting complaint(s) and outside the realm of your complaint(s).
- **Assessment Phase** – An initial evaluation may last from 2-4 sessions. During the assessment phase I am getting to know and understand you, your worldview, strengths, concerns, needs, family, and relationship dynamics, etc. during this phase I am gathering a lot of information. During this phase, it may not feel like we are moving forward quickly, but it is imperative for me to gather this information to assist you the best I can. During this time, we both decide if I am the best person to provide therapeutic services for your specific needs. If you or I determine that I am not the best person to address your needs and treatment plan, then referrals will be made for a more appropriate treatment provider.
- **Goal Development/Treatment Planning** – after we have explored and developed sufficient background to proceed, we will collaboratively identify specific goals for therapy. Therapy is best concluded through mutual agreement among the participants, including myself as a therapist, and you will be directly tied to sufficient progress toward and/or the achievement of the goals we set together. If you are court ordered, we encompass both what is important to you and what the court is requiring of you into the goal. If you are court ordered, it is important to provide copies of documents from the court that states what needs to be addressed during our counseling sessions. After the goal is completed, we will both sign the goal and you will receive a copy.
- **Intervention Phase** – This occurs anywhere from session 2 until graduation/discharge/termination. This phase requires effort both in session and completing any agreed upon assignments outside of session. You will maximize therapy by implementing solutions discussed during session. During this phase, you will progress and make any adjustments to your goals as needed. If at any time you have questions about what I am attempting to do or where we are headed, please do not hesitate to ask.
- **Graduation/Discharge/Termination** – As you progress and get close to completing your goals we will collectively discuss your progress, make a transition plan and decide on the date of graduation/discharge/termination.

Length of Therapy: Therapy sessions are typically weekly or biweekly for 50 minutes depending upon the nature of the presenting challenges. It is difficult to initially predict how many sessions will be needed, but we will collaboratively determine from session to session how much longer therapy is recommended.

Appointments and Cancellations: You are responsible for attending each appointment you agreed upon. You agree to adhere to the following policy: ***If you are prevented from keeping a scheduled appointment, you MUST notify me***

24 hours in advance. If I do not receive a 24-hour notice, you will be responsible for paying the full fee of the session you missed, and that such fee cannot be billed to your insurance company. Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I will, from time to time, take time off for vacation, to attend seminars, and/or become ill. I will attempt to give you adequate notice in advance and will arrange coverage for my emergencies by a colleague. If I am unable to contact you directly due to circumstances out of my control, I will have a colleague contact you to cancel or reschedule an appointment.

Fees: Payment is due at the time of the session. In the event that you miss your scheduled appointment time or cancel less than 24 hours, your credit card or debit card on file will be automatically charged. By signing this document, you agree to such cancellation fees.

I reserve the right to terminate our counseling relationship if more than 3 sessions are missed without proper notification.

I charge my hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of sessions will be billed to your credit card/debit card on file.

In-home/On-site therapy services offer people comfort and flexibility. In-home/On-site services are offered at our regular hourly rate. Cost for travel is based on the regular hourly rate and is determined by time it takes for the therapist to travel from the office to your home or requested place of session and back. Time is configured by therapist tracking and logging actual time or internet sites such as Google, Bing, MapQuest, etc. to determine travel time.

Travel, Court Ordered Appearances, Litigation: Rarely, but on occasion a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. Please know if I get called into court by you or your attorney, which I strongly suggest not being involved in court in order to protect your confidentiality, you will be charged \$250/hour which will include travel to and from the courthouse, time in court, waiting for the court hearing, preparation of documents, etc. A proposed invoice will be drawn up and you will be required to pay prior to the appearance. Any amount that is due to Psychology Support Center or needs to be returned to you after the appearance will be due/returned within 2 calendar weeks.

Copies of Medical Records: Should you request a copy of your medical records they will be dispensed at \$1.00 per page. Payment for your medical records will be due prior or upon receipt of them and can be picked up at our office. Please allow at least 2 weeks to prepare your records. You will also need to sign a release for medical records to be dispensed to either you or designated party, and I reserve the right to provide a summary of process notes, in lieu of the actual notes, as described above.

Phone Contacts and Emergencies: Office hours are from 9:00am – 5:00pm, Monday – Friday. If you need to contact me for any reason please call 305-912-4323. **In emergency situations, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255 or dial 911 if either you or someone else is in danger of being harmed. For residents living in Broward Florida you can call, First Call for Help of Broward at 954-537-0211, Henderson Mobile Crisis Unit for adults at 954-463-0911, or for children at 954-677-3113 ext 3, or call 911 if either you or someone else is in danger of being harmed.**

Part III: Health Insurance

Your Insurance Company – By using insurance I am required to give you a mental health diagnosis that goes on your medical record. I am not required to tell you what I am diagnosing you with, but as best practice it is my policy that we collaborate on this information. You may have had a previous diagnosis from another treatment provider. After my assessment, if I clinically determine that you have the same diagnosis, I will use that diagnosis. If I assess you and clinically determine otherwise, I will discuss that information with you before providing you with either a new diagnosis or secondary diagnosis. It is important to note that some psychiatric diagnoses are not even eligible for reimbursement. This is often true for marriage/couples and family therapy as well. In the event of non-coverage or denial of payment, you will be responsible to pay for such services should you choose to receive them. In the event of nonpayment by you, Psychology Support Center reserves the right to seek payment of unpaid balances by collection agency or legal recourse after reasonable notice to you. Your insurance company will also know the times and dates of services provided. At times, insurance companies may request further information to authorize further service regarding your treatment.

Pre-Authorization and Reduced Confidentiality – When visits are authorized, usually a few sessions are granted at a time. When these sessions are finished, your therapist may need to justify the need for continued service potentially causing a delay in treatment. Sometimes additional sessions are not authorized, leading to an end of the therapeutic relationship even if you feel you have not achieved your therapeutic goals. Your insurance company may request or require additional clinical information that is confidential in order to approve or justify a continuation of services. The information they may request may include: treatment plans, progress notes, and at times the entire medical record is

requested. I cannot assure or guarantee our confidentiality when an insurance company requires this information. Even if the therapist justifies the need for ongoing services, your insurance company may decline services regardless if you think you need continued therapy or not. You are at the mercy of your insurance company to decide your care. You should be aware that some of your personal information might be added to national medical information data banks. For these and other reasons, many therapists openly talk about “the myth of confidentiality” whenever insurance companies become part of the therapeutic process.

Potential Negative Impacts of a Diagnosis – Insurance companies require the therapist to give you a mental health diagnosis (i.e. “major depression” or “obsessive-compulsive disorder”) in order to get reimbursed. Psychiatric diagnosis may come back to negatively impact you in the following ways:

1. Denial of insurance when applying for disability or life insurance;
2. Company (mis)control of information when claims are processed;
3. Loss of confidentiality due to the increased number of persons handling claims;
4. Loss of employment and/or repercussions of a diagnosis in situations that require revealing that you have a mental health disorder diagnosis. This includes but is not limited to applying for job applications, applying for financial aid, and concealed weapon permits.
5. A psychiatric diagnosis can be brought in a court case such as family law, criminal, etc.

It is important for you to know some of the ways having a diagnosis can impact you, so you can empower yourself in regard to your health and medical records. At times, having a diagnosis can be helpful such as in the case of a child needing extra services in the school system or a person being able to receive disability.

EMERGENCY CONTACT:

It is necessary that Sheila Simchon-Steinhof of Psychology Support Center has someone to contact on your behalf. In case of an emergency who should we contact?

Full Name	Relationship	Phone Number(s)
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Please check here that you agree and sign below. Thank you.

____ I agree to allow Psychology Support Center to contact my emergency contact on my behalf in case of emergency

Signature	Date
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Part IV: Consent

1. I have read and understand the information contained in the consent and therapy agreement. Have discussed questions that I have regarding this information with **Sheila Simchon-Steinhof**. My signature below indicates that I am voluntary giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in the consent. I authorize **Sheila Simchon-Steinhof** to provide counseling services that are considered necessary and advisable.

2. I authorize the **release and treatment and diagnosis information** (as described in Part III, above) necessary to process bills for services **to my insurance company**, and request payment of benefits to Sheila Simchon-Steinhof of Psychology Support Center. I acknowledge that I am financially responsible for payment whether or not covered by insurance. Additionally, I acknowledge that I, and not my insurance company, will be responsible for fees associated with appointments cancelled within less than 24 hours. I understand, in the event of nonpayment of fees not covered by insurance, Sheila Simchon-Steinhof of Psychology Support Center may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Sheila Simchon-Steinhof to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Sheila Simchon-Steinhof** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Child/Minor Name	DOB	Date

**Your signature also signifies that you have received a copy of the "Therapy Agreement and Consent" for your records. If you initially received this paperwork through email it will be considered that you have an electronic copy. If you did not receive this through email you can be provided a copy per your request.*

Printed Name	Signature	Date

Witness-Sheila Simchon-Steinhof, LSP, MSW

Date