



INFORMED CONSENT FORM OUTPATIENT SERVICES CONTRACT

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

MENTAL HEALTH SERVICES

Mental health therapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the problems you hope to address. There are many different methods I may use to deal with those problems. Therapy is not like a medical doctor's visit. Instead, it calls for a very active effort on your part. 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. Because 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 benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees as to what you will experience.

Our first few sessions will involve an evaluation of your needs. 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 about whether you feel comfortable working with us. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about the 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.

MEETINGS

I normally conduct an assessment that will last from 1 to 2 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 we agree to begin therapy, I will usually schedule one [50-minute for adults, 45-50 minutes for children and youth] session (one appointment hour) per week, or every two weeks, 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. You will be charged between \$50.00-\$100.00 (depending on your therapist licensure) for a no-show, late cancellation fee.** [unless we both agree that you were unable to attend due to circumstances beyond your control]. [If it is possible, I will try to find another time to reschedule the appointment.]

LATE POLICY

If you are not able to make your appointment at the scheduled time, please reschedule 24 hours in advance. In order to keep the client schedule flowing and keep other patient appointments on time, arrivals that are more than 10 minutes late will need to have their appointment rescheduled.

PROFESSIONAL FEES

In compliance with the “**No Surprises Act Regulations of 2022**”, A Mindful Life Counseling Services wants you to be fully aware of the fees you will be charged for your services. The following is a list of charges for mental health services that you can expect to be billed for services through our agency.

Your specific therapy needs, and treatment plan will dictate the number of sessions you will be responsible for. This is a conversation your therapist will have with you when you discuss treatment planning. Most clients are seen either weekly or every two weeks until completion of services.

If you are covered by insurance, and I am on your insurance panel, I will bill insurance as a courtesy. Billing amounts remain the same and are billed directly to insurance providers. Your insurance co-pay is due at the time of service. Regardless of insurance company coverage, you are responsible for the full amount of fees that are not covered by the insurance company. You are responsible for your co-pay and amounts not covered that are applied to your deductible.

You are required to have a credit card on file for no-show and cancellation fees, and for payment of your co-pay and fees not covered by insurance. Co-pays and your portion of the visit fee are collected on the day of the appointment.

Fees for counseling sessions are as follows:

45-90 Minute initial assessment fee – You may be charged up to \$165.00 for an initial assessment visit.
53-60 Minute Counseling Session fee – You may be charged up to \$150.00 for a counseling session.
38-52 Minute Counseling Session Fee – You may be charged up to \$125.00 for a counseling session.
16-37 Minute Counseling Session Fee – You may be charged up to \$100.00 for a counseling session.
Additional time for a counseling session will be charged in one-half hour increments of the session fee.
Attachment Assessment- \$250.00 (per hour with a 5-hour minimum).

\$50.00-\$100 no-show or late cancellation fee.

In addition, if you are willing to see a student intern in the practice, we offer cash rates of \$50.00 for an initial assessment and \$35.00 per 30–45-minute counseling session. And \$35.00 for no-show or late cancellation fee.

You can consider the above-listed rates and the number of sessions you and I discuss as your **Good Faith Estimate** for these services prior to us beginning the work.

It will be up to you to contact my office for clarification if you have any questions about your bill. It is also up to you to contact your insurance to find out if I am a covered provider or if my services are considered out of network. If we meet more than the allotted time, you will be charged accordingly. If there is a problem with your insurance and you disagree with their determination on payment, you are required to contact your insurance. We do not initiate or manage insurance disputes. In addition to weekly appointments, I charge an hourly rate of \$150.00 per hour for other professional services and this service is billed in 15-minute increments of the fee. These services are not covered by insurance. Other professional services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of us and that is agreed upon. If you become involved in legal proceedings that require our participation, by court order, you will be expected to pay for any professional time we spend on your legal matter, even if the request comes from another party. [We charge \$250.00 per hour for professional services we are asked or required to perform in relation to your legal matter. We also charge a copying fee of \$2.00 per page for records requests.]

LEGAL ISSUES

It is my standard policy that I DO NOT testify in court. I work within the realm of perception and perception is hearsay. I cannot testify to facts, only perception of behavior. For that reason, I ask that you agree that you will not seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion. The only exception to this policy is attachment assessments which the specifics will be agreed upon in advance for that service. If I am subpoenaed to court, you are responsible for the hourly rate of \$250.00 for time discussing the case with you or your legal representative, copying of documentation, travel time, time waiting for court. and time in court.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when such services are requested, and you can consider the above-listed rates a Good Faith Estimate of anticipated costs. Your credit card on file will be charged for fees not covered by insurance.

If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, my office will have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information we will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

We may work with an external billing company for your sessions. Your contact information will be available to them for the purpose of collecting payments and insurance billing.

INSURANCE REIMBURSEMENT

We bill insurance (on plans which we are a provider), as a courtesy, not a requirement of us. When insurance billing is an option, you will be responsible for your co-pay, deductible amount, and any of the fees that insurance does not cover, up to the insurance contracted amount. For instance, you may have insurance that covers 80% of the cost. You will be responsible for your co-pay and the remaining 20% of the bill. You are responsible for informing our office if your insurance changes or becomes inactive. You will still be responsible for the payment in full of services you receive.

CONTACTING US

We are often not immediately available by telephone. Though we are usually in our office between [9 AM and 5 PM], we will not answer the phone when we are with a patient. When we are unavailable, our telephone is answered by confidential voice mail that is monitored frequently. **We will make every effort to return your call within 24-48 hours, except for weekends and holidays.** If you are difficult to reach, please inform us of days and times when you will be available. If you are unable to reach us and feel that you cannot wait for us to return your call, contact your family physician or the nearest emergency room and ask for the therapist or social worker on call. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

ELECTRONIC COMMUNICATION POLICY

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, we have prepared the following Electronic Communication Policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of our profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

Email and Text Messaging Communications

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other

related issues. Please do not email or text me about clinical matters because email and text are not secure means of contact. If you are able to email through an encrypted service, please do so. If you need to discuss a clinical matter, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Secure messaging: A confidential texting application, that provides for secure communication of clinical matters, may be an option for you. You may be required to add an application to your phone to be able to use this service. There may be a cost to you for this application and will be your responsibility. Please speak to me about this option. I currently use *WhatsApp* for secure, end-to-end encrypted messaging. Should you wish to participate in that service, download the app, and I will be easy to find via my current telephone number.

Social Media

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that connection. This is because these types of casual social contacts can create significant security risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

Web Searches

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. Currently there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me (or any professional with whom you are working), please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has significant potential to damage our ability to work together.

CONFIDENTIALITY [for adult patients]

In general, the privacy of all communications between a patient and a therapist is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect you or others from harm, even if I must reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused or has been abused, I must make a report to the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient 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. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity, or identifying information, of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important for our work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

CLIENT SIGNATURE _____ Electronically signed _____ DATE (Electronically dated)

PARENT/GUARDIAN SIGNATURE _____ Electronically signed _____ DATE (Electronically dated)

MINORS

Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. You will be required to provide me with a copy of the most recent custody decree that

establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If there is a custody issue, you will have additional forms to sign that cover our policies with regard to the treatment of minors.

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I would like to meet with your child and get their consent to treat your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances required by law, that their child is receiving a mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements, or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, both parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with Me

In the course of treatment of your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child – not the parents/guardians nor any siblings or other family members of the child. If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that these notes will be available to any person or entity that has legal access to your child's treatment record.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of our profession to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm, and the police.
- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

- Child patients tell me, or I otherwise learn that it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes your child's activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

Example: If your child tells me that he/she has tried alcohol at a few parties, I will keep this information confidential. If your child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I will not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I will not keep that information confidential.

Example: If your child is of age of consent and tells me that he/she is having voluntary, protected sex with a peer of consenting and similar age, I will keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing _____, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents

Although the laws of Utah may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that our agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of \$250.00 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Parent/Guardian of Minor Patient:

By signing this document, you are indicating your agreement to the following to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with our child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

Although I may have the legal right to request written records/session notes since our child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment.

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above.

Parent/Guardian Signature ____ Electronically signed _____ Date: Electronically dated _____