Hendrickson Counseling & Consulting, Inc.
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AGREEMENT FOR PSYCHOTHERAPY SERVICES

Welcome! This document describes the therapy process, potential benefits and risks of therapy, confidentiality, fees, and policies. Please read it carefully and ask any questions that you have.

THE THERAPY PROCESS

Engaging in counseling provides a unique opportunity for self-examination and change. It is an active process that allows us to work together to develop goals and action plans that meet your needs. I approach therapy from a "whole-person" perspective, which is grounded in the person-centered theory of therapy. It is my goal to understand you from where you are in life and to provide both support and challenge as work toward your goals. Specific techniques that may be used are dialogue, interpretation, cognitive reframing, relaxation training, mindfulness, visualization, journaling, drawing, and reading books/articles. I may ask you to complete some homework assignments between sessions to support and extend the work we do in session together. I may also refer you to other professionals as appropriate (e.g., physician for medical evaluation). You have the right to refuse to do anything that I suggest.

Counseling has both benefits and risks. Potential risks may include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. In addition, counseling often requires discussing difficult aspects of both present and past events. If I suggest any techniques that have special risks, I will inform you of those. The potential benefits of counseling are related to the goals that you set for your work. Counseling may lead to a reduction of feelings of distress, better relationships, an increased understanding of yourself, and resolution of specific problems. Of course, there are no guarantees that these outcomes will occur.

Counseling involves a commitment of time and energy, as well as a willingness to examine your behaviors and feelings. Therefore, it is important that you feel comfortable working with me. You have the right to ask questions about anything that happens in therapy. I will discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. In addition, I also have the responsibility to inform you if I do not feel that I am able to address your concerns. If this occurs, I will provide you with referrals as appropriate.

Because of the voluntary nature of your involvement in therapy, you are free to leave therapy at any time. It can be helpful to talk together about your decisions to leave therapy; I encourage you to talk about this in advance with me if possible. In addition, I also reserve the right to end therapy if I believe you are not benefiting from our work together or if I determine that I am no longer able to meet your needs. Should this occur, we would spend time discussing my assessment and what steps may be appropriate. For example, we could decide to adjust our work together and re-evaluate progress at a pre-determined time, you could choose to take a break from therapy, or you could request referrals to other therapists. In the event of a referral, I would be available to facilitate the transfer of care in order to support you and your work. This could include releasing records and/or having a conversation with a new therapist, provided that you sign the appropriate release of information.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of communications between a client and a psychologist. 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 state statutes.

There are situations that require that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing your identity. The other professionals are also legally bound to keep information confidential.

- I use an Electronic Medical Record program called CarePaths. CarePaths allows me to maintain electronic records of our sessions, and submit and receive insurance claims and payments. As required by HIPAA, I have a formal business associate contract with this business, in which it promises to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with a copy of this contract.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am *permitted or required to disclose information without either your consent or authorization*. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. Examples of such disclosures include:

- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided to you, such information is protected by the psychologist-client privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a **court order.** If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court may be likely to order me to disclose information.

- If a government agency, pursuant to their lawful authority, is requesting the information for health oversight activities, I may be required to provide it for them.

- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

- If a client files a worker's compensation claim, I must, upon appropriate request, disclose information related to the claim to appropriate individuals, which may include the patient's employer, the insurer, or the Department of Labor and Industry.

There are some situations in which I *am legally obligated to take actions necessary to attempt to protect you and/or others from harm* and I may have to reveal some information about a client's treatment. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. Examples of such disclosures include:

- If I believe that you present a serious, imminent, and specific threat of physical violence to yourself or another, I may be required to disclose information necessary to take protective actions. These actions may include notifying the potential victim, contacting your family or others who can help provide protection, contacting the police, or seeking your hospitalization.

- If I know or have reason to believe reason a child is being neglected, physically or sexually abused, or has been neglected/physically/sexually abused within the preceding three years, the law requires that I file a report immediately with the appropriate government agency, usually the local child welfare agency. Once such a report is filed, I may be required to provide additional information.

- If I have reason to believe that a vulnerable adult is being or has been maltreated or if I have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, the law requires that I file a report immediately with the appropriate government agency, usually an agency designated by the county. Once such a report is filed, I may be required to provide additional information.

- In most cases, the parents/guardians of individuals under the age of 18 have a legal right to the mental health records of the minor.

- The next-of-kin of a client who has died may have access to the client's records.

- Misconduct by other health care professionals, including sexual misconduct by a mental health professional, may require that I make a report to appropriate licensing boards.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex. In situations where specific legal advice is required, formal legal advice may be needed.

COUNSELING RECORDS

I am required to maintain records of our work together. I maintain a paper file that contains any paperwork you have completed, copies of receipts of payments, and other documentation relevant to your treatment. I also maintain electronic copies of correspondence that I generate. These documents are maintained on a laptop computer, which is protected by full-disk encryption, and is used only by me. In addition, I use CarePaths, an electronic medical record product. I have policies and procedures in place to ensure the security and privacy of both the files and laptop. I can provide you with a copy of those policies if you wish.

In accordance with federal and state law and professional standards of practice, files will be kept for ten years after completion of therapy. In the case of clients who were under the age of 18 at the onset of psychotherapy, files are kept for 10 years after the person turns 18. In the event that I become injured or incapacitated, a professional colleague has detailed instructions on how to access my files and would notify you regarding my status.

The federal and state laws and professional practice standards require that I keep Protected Health Information (PHI) about you in your clinical record. Except in unusual circumstances that involve the potential of danger to yourself and/or others, you may examine and/or receive a copy of your clinical record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents.

If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you rights with regard to your clinical records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your clinical records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

FEES AND PAYMENT

Fees for services are:

Diagnostic Interview/Initial Intake (60-90 minutes)	$225
Psychotherapy (45-50 minutes)	$150
Half-hour Psychotherapy	$ 75
Group Psychotherapy	Varies

If you arrive late, the full session fee will be due and we will end on time. Fees are due at each session (check, cash, debit/credit card). If you have a co-payment with your insurance, you must pay the co-pay at the end of each session. Payment schedules may be negotiated under certain circumstances. I will give you advance notice if my fees change. Checks should be made payable to **Hendrickson Counseling & Consulting, Inc**.

In the event that I am required to participate in legal proceedings, you will be charged for my professional time, including all preparation time and travel costs. The hourly rate for involvement in legal proceedings is **$200/hour**, billed in increments of 15 minutes. This includes time spent in court, depositions, preparation of reports or letters, and communication with involved parties.

Fees for other professional services will be charged at my standard rate of **$150/hour**. These services include report writing, telephone conversations lasting longer than 15 minutes, and meetings/consultations with other professionals that you request and authorize.

If for any reason you do have an overdue bill with me and refuse to pay, I reserve the right to give your name and the amount due to a collection agency. If the bank for any reason returns a check, a $35 returned check fee will be due.

NO SHOW/CANCELLATION POLICY

Missing a session without canceling or canceling less than 24 hours (weekends included) in advance will result in a charge of **50% of the regular session rate**. *Please keep in mind that insurance companies generally will not provide reimbursement to you for missed session charges.* You can reach my confidential voice mail (612-845-8768) at any time to leave a message of cancellation. In the case of severe weather, we can consult together about whether we can safely meet. Since there are times when emergencies arise (illness, accidents, etc.), I will give individual consideration to such circumstances and

may waive the late cancellation fee. If late cancellations or missed appointments become a pattern, we will address this in the course of treatment.

INSURANCE REIMBURSEMENT

By agreeing to use health insurance benefits, your therapy becomes a permanent part of your medical record. Some plans require authorization (often called Prior Authorization) before they provide reimbursement for mental health services. The insurance company may request a range of information, including specific details of the nature of your concerns, before approving coverage. The insurance company may limit the number of sessions and the types of therapy you may obtain. Insurance companies (e.g., life insurance, etc) and future employers may also have access to your medical records.

Health insurance policies require that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. I will provide you with a copy of any report I submit, if you request it. **By signing this Agreement, you agree that I can provide requested information to your carrier.**

If you have questions about your plan's coverage, call your plan's Customer Service phone number.

RED FLAG COMPLIANCE

To comply with federal regulations, I am required to verify the identity of all individuals who either use insurance or are billed for services provided. These rules are intended to prevent medical identity theft. **Please bring a current photo identification (driver's license, passport, or other government issued ID) to our initial meeting**. This identification must contain your current address. If your photo ID does not have your current address, please bring additional proof of residence such as a current utility bill or lease that does contain your name and current address.

PHONE CALLS AND EMERGENCY CONTACTS

I am generally in my office on Mondays and Thursdays. You may leave messages for me at my confidential voice mail (612-845-8768). *Because of the part-time nature of my practice, I am not available between sessions for additional contact.* If you feel that you would be better served by meeting with someone who has more availability, I will help you find an appropriate referral. As part of the initial intake session, we will discuss emergency contact options.

I do plan for time away from the office several times during the year. With the exception of emergencies, I will provide you with advance notice of those breaks. When a vacation is planned, we will review emergency contacts and procedures as appropriate.

If at any time you feel physically unsafe, contact 911 or go to your nearest emergency room for assistance.

ELECTRONIC COMMUNICATION & SOCIAL NETWORKING

I do not respond to or accept invitations to connect on any social networking site (e.g., LinkedIn, Facebook, etc). This is to protect your privacy and to also maintain clear boundaries in our therapeutic work.

I cannot guarantee the privacy of any communication that is conducted via e-mail or text messaging. I urge you to use caution in sending sensitive or confidential information in this way. I do not conduct therapy over e-mail or text messages. However, text messaging and e-mailing can be a convenient manner to change or confirm appointments. You will be given a choice about whether you are comfortable with this and you are free to decline this option or change your mind at any time.

Please see Communications Policy for more detailed information.

LICENSURE AND EDUCATION

I am licensed as a psychologist by the state of Minnesota. My license number is LP4455. I have a PhD in Educational Psychology (Counseling & Student Personnel Psychology) from the University of Minnesota. I have competence to practice in the following areas: individual and group psychotherapy with adults and adolescents; career counseling with adults and adolescents; counseling supervision; consultation/outreach; crisis management/intervention; interpretation of personality and career assessments.

DUE PROCESS/COMPLAINTS

If you are unhappy with what's happening in therapy, I hope you'll talk about it with me so that I can respond to your concerns. I will take your concerns seriously, and listen to you with care and respect. If you believe that I've been unwilling to listen and respond, or that I have behaved unethically, you may contact the Minnesota Board of Psychology, 2829 University Avenue SE, Suite 320, Minneapolis, MN 55414 (phone: 612-617-2230).

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CLIENT CONSENT TO PSYCHOTHERAPY

I have read this document, have asked any questions, and I understand this agreement and agree to abide by its terms during our professional relationship.

I agree to undertake therapy with Susan M. Hendrickson, PhD, LP. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Dr. Hendrickson.

CLIENT SIGNATURE **DATE**

PARENT/GUARDIAN SIGNATURE *(if client is under 18)* **DATE**

THERAPIST SIGNATURE **DATE**

CONSENT FOR PAYMENT OF PSYCHOTHERAPY SERVICES

My signature indicates that I understand that I am responsible for payment of all services rendered. If I am utilizing health insurance benefits, I authorize Hendrickson Counseling & Consulting, Inc to release all billing and diagnostic information to authorized third party payers. I understand that I am responsible for any services provided that are not covered by my insurance policy.

CLIENT SIGNATURE **DATE**

PARENT/GUARDIAN SIGNATURE *(if client is under 18)* **DATE**