CLIENT SERVICE AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. By signing this document, I agree that all my questions were answered or I had no further question, and I understand at any time in the future I can ask my therapist any questions pertaining to this Agreement.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first few sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist or if you wish to terminate the relationship, I will be happy to help you set up a meeting with another mental health professional.

APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours-notice. If you miss a

session without canceling, or cancel with less than 24 hour notice, my policy is to collect the amount designated on the financial agreement (depending on the source of funding for your treatment), 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. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES

If you are self-paying, the standard fee for the initial intake is $100.00 and each subsequent session is $100.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by credit card or cash.

In addition to weekly appointments, it is my practice to charge you $100 per hour for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

PROFESSIONAL RECORDS

I am required to keep clinical records of the psychological services that I provide. Your records are maintained in a secure location in the office and will be kept for at least seven years. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. These records are not transcripts of the visits we have and are not intended to be, but contain my overall impressions and summaries. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices, located in the binder in our waiting area. You have been provided with a copy of that document and can ask any questions you may have about those issues. Please remember that you may reopen the conversation about confidentiality at any time during our work together.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For

children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING ME

I am often not immediately available by telephone, nor is therapy best conducted over the phone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) contact the Help Line at 512-472-43572) go to your Local Hospital Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences and provide you with the name and phone number of the mental health professional covering my practice. Please limit texts to minor issues that may arise, scheduling, etc. In-depth discussions should primarily occur face-to-face.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion or national origin. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients. And you have the right to receive your medical record or have me send it to who you wish if you issue a written request and the authorization is filled out completely.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Description of Authority

Demographic Information

Dr. Tania Glenn & Associates, PA

Client's Name:_____ Date: _____

Gender: _____M _____F Date of birth: _____ Age: _____

Form completed by (if other than client); _____

Address: _____ City: _____ State: _____ Zip: ____

Phone (home): _____ (work): _____ ext: _____

Mobile: _____ Email Address: _____

Social Security Number: ____-_____-_____

Other Insurance Name: _____ ID Number: _____

Name of Insured: _____ Relationship to you: _____

Emergency Contact Information

Name: _____ Relationship to you: _____

Phone number(s): _____

Address: _____

If you need any more space for any of the questions please use the back of the sheet.

Primary reasons for seeking services:

Goals for therapy:

_____

_____ _____

Signature of Client or Representative Signature of Clinician

Client E-mail/Texting Informed Consent Form

1. Risks Associated with e-mail/texting: The transmission of client information by e-mail and or text has a number of risks that you should be aware of prior to the use of this form of communication with your therapist:

a. E-mails and text senders can easily misaddress an e-mail or text and send the information to an undesired recipient.

b. E-mails and texts can be intercepted, altered, forwarded or used without authorization or detection.

c. E-mails and texts may not be secure and therefore it is possible that the confidentiality of the communication may be breached by a third party.

d. There is a potential for technological failure.

2. Conditions for the use of e-mail and texts: Prior to electronic communication, your identity must be verified. Please list your telephone number and/or email address you will use. After the initial communication, your number and email address will verify your identity to your therapist.

Phone number: _____

Email address: _____

Therapists cannot guarantee, but will use reasonable means to maintain, security and confidentiality of email and text information sent and received. Your therapist is not liable for improper disclosure of confidential information that is not caused by therapist intentional misconduct.

3. Clients must acknowledge and consent to the following conditions prior to the use of e-mail and texts for communications.

a. E-mail and texting are not appropriate for urgent and emergency situations. Clinician cannot guarantee that any particular email and or text will be read and responded to within any particular period of time. If Clinician is not available and it is an emergency, you should call 911 or go to the closest emergency room.

b. E-mail and texts should be concise and mostly consist of scheduling issues or small issues that can be dealt with in this forum. Complex and sensitive issues can be discussed in scheduled session time.

c. Clients should not use email or text for communication of sensitive mental health or medical information.

d. Therapist is not liable for breaches of confidentiality caused by the client or any third party.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and or texts between my therapist and me and consent to the conditions and instructions outlined as well as any additional instructions that may be imposed by my therapist.

Printed Client Name: _____

Client Signature _____ Date _____

Clinician Signature _____ Date _____

Therapeutic Fee Schedule

Name of Patient: _____

Name of Responsible Party: _____

Private Pay is $100.00 per hour for clients not covered by departmental contracts or other resources. Be sure that you have clarified this with your counselor.

All major credit cards are accepted.

Name: _____ **Date:** _____

Please identify your concerns about this adult by placing a number beside a problem, using the choices below. Do not place numbers next to problems about which you have no concerns.

8 = Slight concern but I have *not* thought about getting help for this problem
7 = Some concern *or* I have thought about getting help for this problem
6 = Moderate concern *or* someone has encouraged me to get help for this problem
5 = Serious concern *or* a few people have encouraged me to get help for this problem
4 = Major concern *or* many people have pressured me to get help for this problem
3 = Unable to function *or* I am totally unable to do what is age-appropriate in this area
2 = A danger to self or others some of the time
1 = A persistent danger to self or others

_____ Acts without Thinking (Hyperactive or Impulsive)
_____ Aggressive Behavior
_____ Alcohol Consumption
_____ Anger
_____ Anxious, Tense, Worried
_____ Appetite
_____ Arguing
_____ Bad Dreams or Nightmares
_____ Being Ignored or Abandoned
_____ Bothered by Recurring Thoughts
_____ Bothered by a Traumatic Event
_____ Bullying or Threatening Others
_____ Career
_____ Confused
_____ Critical of Self
_____ Destruction of Property
_____ Eating
_____ Energy Level
_____ Family
_____ Fears or Phobias
_____ Feeling Detached from Myself
_____ Fidgeting, Squirming, "Hyper"
_____ Fighting
_____ Finances
_____ Grief, Bereavement
_____ Guilt or Shame
_____ Health Problems
_____ Illegal Drugs or Substances
_____ Illegal or Unlawful Behavior
_____ Impact of Adult's Problems on Spouse
_____ Impact of Adult's Problems on the Children
_____ Irritable
_____ Job/Work Attendance
_____ Job/Work Performance
_____ Job/Work Satisfaction
_____ Lack of Interest/Enjoyment in Life
_____ Legal Problems
_____ Lonely
_____ Lying
_____ Making or Keeping Friends
_____ Marriage
_____ Memory
_____ Mood Swings
_____ Pain
_____ Panic
_____ Parent–Child Relationship
_____ Paying Attention or Concentrating
_____ Perfectionistic
_____ Performing Unusual Habits or Rituals
_____ Planning or Organizing Work
_____ Procrastination
_____ Restless
_____ Sadness/Depression
_____ Satisfaction with Life
_____ Seeing or Hearing Strange Things
_____ Self-Injurious Behavior or Suicide
_____ Sexual Behavior or Responses
_____ Shy
_____ Sleeping
_____ Social Skills
_____ Social Support (Family and Friends)
_____ Stealing
_____ Strange, Weird, or Peculiar Behavior
_____ Suspicious or Mistrustful
_____ Thinking about Suicide
_____ Trusting Other People
_____ Using Nonprescription Drugs or Substances
_____ Weight
_____ Well-Being
_____ Other: _____
_____ Other: _____
_____ Other: _____