Welcome to Children’s Empowerment Group, LLC! We are looking forward to working with you on the personal, relationship, family, or other issues that brought you here. This agreement contains important information about our professional services and policies. You are provided with summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of disclosure of treatment, payment, and healthcare operations. HIPAA requires that you be provided with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment, and healthcare operations.

**Psychological Services**
A therapy session usually consists of a 45-to 50-minute or a 60 minute time period. During the first session, which usually takes 60-90 minutes, we will discuss the history and current issues involved in what brought you and/or your child or family into the office. We will also spend time looking at options, strategies, and ways to achieve the goals that you have for yourself and/or your child or family.

**Benefits and Emotional Risks**
While the benefits of a psychological evaluation, psychotherapy, or other psychological treatments are generally likely to outweigh possible risks, the outcomes and side-effects cannot be predicted with certainty. Persons being evaluated or involved in therapy may experience a wide range of emotions, and it is not unusual to feel vulnerable or stressed. The therapeutic experience may arouse feelings or produce insights of which you were unaware, or which you might not wish to experience. While the goals of psychological services are generally to advance the understanding of problems and to increase adaptive functioning and positive emotional well-being, it is sometimes possible that symptoms may not improve. Any problems or uncomfortable feelings you experience should be discussed in your sessions.

**Confidentiality**
Federal and state laws regulated by HIPAA require us to maintain the privacy of your PHI. In most situations we can only release information about your treatment upon obtaining your written authorization. However, the following circumstances are exceptions and no authorization is required:
• **Administrative and Judicial proceedings.** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated by a third party or when the evaluation is court ordered. You will be informed in advance if this is the case.

• **Child abuse or neglect.** If we have reason to believe a child has been subjected to abuse or neglect, we must report this belief to the appropriate authorities.

• **Adult and domestic abuse.** If we have reason to believe that a dependent adult has been subjected to abuse, neglect, self-neglect, or exploitation, we must disclose this information to the appropriate authorities.

• **Serious threat to health or safety.** If you communicate a specific threat of imminent harm against another individual, or if we believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, we may make disclosures that we believe are necessary to protect that individual from harm. If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we may make disclosures we consider to be necessary to protect you from harm.

• **Money matters.** PHI may be released if necessary to collect fees owed for professional services, provided that only information relevant to the financial resolution may be disclosed.

• **Consultation with another professional.** We may occasionally find it helpful to consult about a case with other professionals. In these consultations, we make every effort to avoid revealing the identity of the client. The other professionals are also legally obliged to keep the information confidential. Unless you object, we will not tell you about these routine consultations unless we feel it is important to our work together.

• **Administrative staff.** We may employ staff that need to access to PHI for billing, scheduling, and quality assurance purposes. All staff will have received training about how to protect your privacy.

Other laws may dictate the release of confidential records and information in other specific circumstances. For example, information may not be afforded the usual confidentiality protections when professional services are provided for the purpose of child custody or visitation evaluation; in the course of a court-ordered evaluation; or, in the case of future legal action involving child custody, visitation or parental rights. Information which may be released will not include copies of test materials or related documents. Psychologists are generally allowed to share such information only with an individual with appropriate training and qualifications, such as licensing for the use of such materials.
Treatment of Teenagers
Privacy in therapy is very important, especially with teenagers. Additionally, parental involvement is also essential to successful treatment and progress. Therefore, it is our general policy that children between the ages of 13-17 who are not emancipated, most of the details of therapy will be treated as confidential. Parents or guardians have the right to general information but not necessarily the specifics of the sessions. If any information shared by the teen involves dangerous behavior or intention to engage in dangerous behavior the parents or guardians will be notified.

Treatment of Families and Groups
In family and group therapy everyone involved must have a clear understanding of the limits of confidentiality. Family and group members are asked to keep information discussed during therapy confidential, but the discretion of members cannot be guaranteed.

Professional Records
The law and standards of our profession require that we keep treatment records. You are entitled to receive a copy of your records unless we believe that seeing them would be emotionally damaging, in which case a summary of your record will be created and given to you. If you wish to see your records, we recommend that you review them in our presence so that we can discuss the contents. If records are requested and authorization is granted for their release, an appropriate fee will be charged to the client for preparation time of the record and the cost of the copies.

Missed Appointments and Cancellations
Your appointment time has been reserved just for you. Please give us at least 24 hours notice if you need to change or cancel your appointment time by leaving a message on the voice mail. Apointments cancelled with less than 24 hours notice will result in you being charged the full session fee. We understand that emergencies do happen so please let us know of extenuating circumstances and we will determine if a fee is warranted. If you are more than 15 minutes late, your appointment may need to be rescheduled. It is important to note that insurance companies do not provide reimbursement for cancellations or missed appointments.

Emergencies After Hours
Due to our work schedules we are often not immediately available by telephone and we will not usually answer the telephone when we are with a client. When we are unavailable, the telephone is equipped with voice mail which is monitored frequently. We will make every effort to return your call on the same day you make it with the exception of holidays and week-ends. If you cannot reach us in an emergency, you should seek assistance at the emergency room of the nearest
hospital. If we plan to be away from the office for an extended time, we will give you advanced notice and make arrangements for a trusted colleague to take emergency calls for us.

**Insurance**

In order for us to set realistic treatment goals and priorities, it is important to evaluate what financial resources you have available to pay for treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. You should carefully read the section in your insurance coverage booklet that describes mental health services and if you have questions about the coverage, call your plan administrator. We are participating providers with **some** insurance companies. If you have insurance coverage other than what we accept you will need to inquire about your out-of-network benefits. If you have out of network benefits, we will provide you with the necessary information that you can submit to your insurance company for reimbursement. However, you are responsible for full payment of our fees at the time of service.

**Professional Fees**

Currently, the fees for our Doctoral level services are $185.00 for the initial intake, $175.00 for a 60 minute session, and $150.00 for a 45 to 50 minute session. The fees for our Master’s level services are $150.00 for the initial intake, $140.00 for a 60 minute session, and $125.00 for a 45-50 minute session. Psychological evaluations vary greatly in price but the hourly rate is $175.00. Fees may apply not only to direct contact such as test administration, therapy, or interviews; but may also apply to related activities such as scoring and interpretation of tests, preparation of written summaries or reports, providing professional consultation to schools when requested, or extended (more than 15 minutes) telephone contacts.

We accept cash and most major credit cards as forms of payment. You are financially responsible for all fees or charges arising from the services provided and charges for other utilization of our professional time related to the provision of services, now or in the future, regardless of whether the services or related use of professional time were requested by us or on our behalf, or necessitated by other circumstances including but not limited to a subpoena or other court process. Payment for any such future charges shall be made at our usual and customary rates at that point in time.
SUMMARY OF THERAPIST-CLIENT AGREEMENT

Please initial all of the statements below and if they do not apply please write N/A.

_____ I have received a copy of the Maryland Notice of Privacy Practices form and have had a chance to ask questions and have them answered.

_____ I understand that if I am unable to reach the therapist directly in case of emergency, I should follow the emergency contact instructions on the office voicemail and/or I should contact the nearest emergency room.

_____ I understand that payment in full is required at the time that services are rendered unless other arrangements have been made. Any unpaid balances are due within 30 days of treatment.

_____ I understand that I may be charged the full session fee for missed appointments unless I notify the therapist at least 24 hours in advance.

_____ I request and authorize the therapist to provide psychological services to my child, family, and/or myself. These services may include testing, therapy, and any additional psychological services deemed appropriate for the client(s).

_____ I certify that I have legal custody and/or other required legal standing to request and authorize professional psychological services for my child.

Signing this document represents an agreement between us. The signature(s) below indicates that I/we have read, discussed, understand, and agree to this agreement and the points presented above.

Signature(s) of client or parent/guardian ___________________________ Date __________

Printed Name(s) ___________________________________________

Child's Name (if applicable) ________________________

For Professional Use Only
No signature above is for the following reason:
_ Individual(s) refused to sign
_ Communications barrier prohibited obtaining a signed acknowledgement
_ Emergency services prohibited obtaining a signed acknowledgement
_ Specify other reasons ________________________________________________________________

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