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CLIENT HANDBOOK

Thank you for choosing me as your therapist. I am committed to your counseling experience being a partnership. The integrity of our partnership will be best protected by beginning with a clear expectation regarding the rights and obligations of you, the client, and I, the clinician. Some of these rights and obligations are imposed by Florida law, while others are established herein by contractual agreement between us. In order to effectively serve your needs, I want you to feel comfortable with me. If you have any questions or concerns that you feel will help me better serve you, please bring them to my attention. Absent a memorandum signed by both of us indicating otherwise, this handbook establishes the terms and conditions pursuant to which services are provided and is binding upon both of us.

CONFIDENTIALITY

All communications between you and me in the course and furtherance of the psychotherapeutic relationship will be treated as strictly confidential. As the client, you control whether or not I may disclose confidential information. You have the power to waive confidentiality. In addition, I do not get involved in litigation and ask that you do not involve me in custody or domestic disputes. I, as your therapist, am interested in the welfare of the whole family. There are exceptions to confidentiality mandated or implied by Florida law. Under the following circumstances, I will breach confidentiality.

EXCEPTIONS TO CONFIDENTIALITY AND/OR PRIVILEGE

Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose your protected health information without your consent or authorization in the following circumstances:

- **Child Abuse:** If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Florida Department of Child and Family Services.

- **Adult and Domestic Abuse:** If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

- **Health Oversight:** If a complaint is filed against me with the Florida Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

- **Worker's Compensation:** If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

Additional Situations in which Privilege does not Apply or is Limited Include:

- If you bring a lawsuit against this therapist
- If another person is in the room
- If you are being evaluated by a third party

DISCLOSURE OF INFORMATION

Any time you give permission to provide information to another party, there is limited confidentiality. In these cases and in most situations listed above, I can reveal information only to someone who has a **need to know**, and entire records and irrelevant information may not be disclosed. Whenever information will be

shared with other persons, their names or positions will be specifically listed, and every effort will be made to ensure that the receiving person also maintains confidentiality. The major situations in which I may disclose information with permission are:

1. If you are being evaluated or treated for a third party (disability, etc.)
2. If you request or give permission for information to be obtained from or provided to a third party (therapist, physician, teacher, employer, etc.)
3. If I am unavailable and temporary coverage is required (emergencies, vacations, etc.)
4. If you are using third-party coverage (insurance) to pay for therapy
5. In the event of my disability or death

Also, you may have access to your records, although it may be best for me to discuss the items contained in them with you or to provide you with a summary for a specific purpose.

LIMITED WAIVER OF CONFIDENTIALITY

On occasion, I may consult with my professional peers regarding a clinical matter. My professional peers are likewise bound by confidentiality. You authorize the release of information reasonably necessary to such a consultation, unless otherwise specified in writing. It is understood that your name will not be released to the consulting clinician in such cases.

COUPLES THERAPY

Special circumstances apply to situations in which another person is involved in treatment. Other individuals in the room are not bound by privilege and may possibly not hold information confidential; I am not responsible for disclosure by these individuals. In situations where you are in therapy with another person (e.g. spouse, family member) and secret information in revealed by one person to me, it is understood that I will not reveal the information but may determine that it is not workable to continue treatment. Should this situation arise, I will discuss it with you thoroughly.

REFERRALS

You and I may deem it appropriate to make a referral to another practitioner for specific services. I know many professionals in my field and in related fields and will gladly make any necessary arrangements. My knowledge as to their competence comes in part from reports from other clients, and therefore, I cannot take personal responsibility for their competence.

VACATION AND ILLNESS

On occasion, I will take time off for vacation, to attend seminars, or because I am ill. Psychotherapy is a uniquely personal service, and therefore, therapy may be briefly interrupted. However, I will attempt to give you adequate advance notice.

TELEPHONE AVAILABILITY

I try to be available to my clients by telephone for any emergency. In the case that I cannot be reached in an emergency, crisis assistance can be obtained by calling (813) 234-1234 or 211 from any land-line in Hillsborough County.

DISPUTE RESOLUTION

Clients may have strong feelings towards their clinician. I would like you to discuss these feelings with me as a part of the therapeutic relationship. In the extremely rare circumstance that we have a dispute that cannot be resolved between us, we both agree to submit the dispute to binding arbitration. If an arbitrator and simple arbitration rules cannot be agreed upon by us, we agree in advance to be bound by the rules of the American Arbitration Association and accept a randomly selected arbitrator from a list of approved arbitrators maintained by the court of this circuit.

OFFICE FINANCIAL POLICY

The integrity of our partnership will be best protected by beginning with a clear expectation regarding payment of services and protocol for missed appointments. An important component to treatment is commitment. Commitment includes open and honest communication, coming to appointments on time, and payment for treatment sessions. Please consider that payment of your bill is a part of our partnership.

TIME OF PAYMENT

My standard fee is $120 per 50 minute session. This includes individual and couples psychotherapy. A sliding scale fee based upon combined household income is available.

Your payment is to be paid in full at the time of each visit, including your first visit. Only checks or cash in the exact amount are accepted (I do not keep change in the office). Returned checks will be assessed a $25.00 service charge.
Your regular fee will be charged for any additional professional services rendered at your request, such as phone contacts over 5 minutes, preparation of special forms, consultations with other professionals, etc.

It is your responsibility to initially verify your insurance coverage. If I have a contract with your insurance company, I will file the claim but the responsibility lies with you to ensure that it is paid.

NO-SHOW AND CANCELLATION POLICY

Your visit has been reserved for you. As a clinician, what I provide to my clients is my time. It is generally impossible to fill a time slot that I had reserved for a client on short notice. **Therefore, unless canceled at least 24 hours in advance, the policy is to charge the fee of the session for missed appointments.** I have a voicemail system that is available during my non-business hours to take messages to cancel appointments.

TERMINATION

A clear, thoughtful, and planned ending to therapy can have emotionally strengthening effects for clients. I recommend that you openly discuss with me your plans to end therapy at least three sessions prior to your last session. Devoting some time during each of your final sessions to discussing your feelings related to termination and what it will mean for you is an important component of the therapeutic relationship. The final closure session is a unique opportunity for us to exchange our observations of what you have accomplished and gives you the opportunity to discuss any concerns you might have. While your notification of termination three sessions prior to the final session is not required, it is strongly recommended.

INFORMED CONSENT

I authorize treatment to be provided to myself or my child and understand that I am responsible for all charges resulting from treatment.

I have received a client handbook and agree with the terms, policies and conditions stated therein.

I understand that I have the right to withdraw from treatment at any time.

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Signature of Client

Date _____ / _____ / _____

_____

Signature of Client

Date _____ / _____ / _____

_____

Signature of Therapist

Date _____ / _____ / _____