RACHEL WHETTEN COUNSELING AND PSYCHOTHERAPY

OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and make note of any questions you might have so that we can discuss them at our next session. Signing this document represents an agreement between us.

PSYCHOLOGICAL SERVICES

I provide psychotherapy and counseling services to my clients. I employ a variety of techniques to address problems and achieving agreed upon goals. I believe clients bring an array of strengths and challenges to therapy and we will work to elicit all of them in our sessions together. Our treatment can vary in length, from brief treatment models to longer-term therapy. While goals in therapy are to address problems and challenges, treatment can bring up difficult thoughts and emotions that include: sadness, anxiety, anger, guilt among others. Fortunately, therapy has many evidential benefits including increased self-knowledge, improvement in interpersonal relationships and reduced distress. In order for the therapy to be most successful and benefit you the most, you will have to work on things we talk about both during our sessions and outside of sessions. There are no guarantees as to what your specific outcome(s) will be.

Our first few sessions will involve an assessment of your needs and goals for treatment. This assessment could take more than one session. Following these initial sessions, I will offer my impressions and thoughts for a treatment plan and discuss with you any questions or concerns you may have. From time to time, I may conclude that I am not the right therapist for your goals and/or do not provide the specific treatment I believe would best serve you. This is also a time for you to decide if you feel comfortable with me as your therapist. If either of these cases occur, I will give you referrals to other practitioners whom I believe are better suited to help you.

MEETINGS

If we agree to begin psychotherapy, we will meet for 45-53 minute sessions generally once a week. There are exceptions to this, where more frequent sessions are indicated. Once we have scheduled your appointment, you will be expected to pay for a full fee (including co-pay) unless you provide 24 hours [1 day] advance notice of cancellation [there are emergency exceptions]. For example, if your session is 9am on Monday morning, notice will need to be provided as of 9am on Friday morning. **Please be advised that insurance does NOT reimburse for no-shows or late cancellations.** To cancel an appointment, please call me at 919-619-0891. An email is not sufficient for cancellation purposes. If you are late or no show for more than 2 sessions in a row without making contact with me within 2 days of the missed session, I will assume you are terminating services and will release any additional scheduled appointments.

PAYMENT:

My hourly fee is $120. If we meet more than the usual time, I will charge accordingly in 15 minute increments. If additional services are needed (consulting with other professionals, letter writing, treatment summaries, or telephone conversations that last longer than 10 minutes, I charge this same hourly rate broken down in 15 minute increments. If your account is past due more than 30 days, I reserve the right to discontinue services and provide you with referrals to another service provider. If your account has not been paid for more than 60 days, I reserve the right to use legal means to obtain payment. If such legal action is necessary, I will include the cost of these services in the claim.

I reserve the right to not participate in legal proceedings. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. Due to the difficulty of legal involvement, I charge $200 per hour for preparation and attendance for legal proceedings. professional services. I also charge a copying fee of $0.05 per page for records requests. If you are seeking services for fulfillment of court-mandated treatment or anticipate legal proceedings requiring my involvement, please inform me at our first contact and I will refer you to another provider.

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.

INSURANCE REIMBURSEMENT

If you are using insurance to pay for services, the cost of your co-pay or co-insurance is determined by the insurance company. I ask that you call your insurance or look up the co-pay or co-insurance ahead of time. If you are unaware of your co-pay or co-insurance at the time of your appointment, I will charge you the full cost of the session. Please be aware of your deductible, if you have one, and whether or not you have met it. However, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. Your insurance may require prior authorization. Please contact them to find out. Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Other charges may be incurred that are out of pocket/self-pay such as report writing, completing forms, telephone conversations longer than 10 minutes, consulting with other professionals and preparation of treatment summaries.

Please be aware that most insurance companies will only pay for face-to-face treatment with a diagnosis and dates of your visits. If it is a managed care company/organization they may require more information regarding symptoms and progress. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by the insurance contract]. ***You understand that, by using your insurance, you authorize me to release treatment and diagnostic information to your insurance company. I will try to keep that information limited to the minimum necessary.***

CONTACTING ME

There may be times you need to contact me outside of session hours. The best way is to call me at 919-619-0891. I am often not immediately available by telephone. If you need urgent or immediate assistance, please call 911 or go to the local emergency room and ask to speak to the psychiatrist on-call. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

ELECTRONIC COMMUNICATION POLICY

My computer is password protected as is the office internet. My emails, however, are not encrypted therefore *I cannot guarantee confidentiality of email communication.* If you choose to communicate confidential information via email, you are doing so with awareness that email that is not encrypted can be intercepted.

CONFIDENTIALITY [for adult patients]

In general, the privacy of all communications between a provider and client is confidential and I can and will only release information about our work together to others with your written permission. There are however, a few exceptions:

If I believe you are at risk of harming yourself or others, I am required by law to contact the authorities or the other person at risk to allow them to take protective measures for you or for the other person. This can include hospitalization and/or law enforcement.

If I believe a child, elderly or disabled person is being abused or neglected I am required by law to to report this to an appropriate NC State agency. I am also required to report minors witnessing domestic violence.

If you are involved in a court proceeding, the court can order me to release your information. If you are involved with a court proceeding, please consult with your attorney about whether the court may be inclined to order me to disclose.

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.

It is very rare I would be asked to disclose information and it is my policy to discuss with you any of these situations should they occur.

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 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 to our work together.

This written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, but please discuss any questions or concerns that you may have at our next

session. I will be happy to discuss these issues with you and provide any clarification. As I am not an attorney, I am unable to provide, formal legal advice.

CONSENT FOR TREATMENT

Your signature below indicates that you have read, reviewed and understood the information in this document and agree to abide by its terms during our professional relationship. While you are obligated to continue a therapeutic relationship with me, your signature below indicates your consent to undergo therapy with Rachel Whetten of Rachel Whetten Counseling and Psychotherapy

PATIENT PRINTED NAME _____

PATIENT SIGNATURE _____ DATE _____

Note to clinicians: *The sample language below relates to working with children and teens in individual treatment. We recommend that clinicians meet first with parents, and then with the children or teens (as appropriate to their developmental level). With divorced or never married parents who cannot meet together, the professional can meet with each parent individually prior to meeting together with parent-child dyads. This allows the clinician to clarify whether parents have agreed to the structure proposed in the treatment contract, and will assist in the discussion with the child or teen regarding the parameters of confidentiality, information sharing, and records access. It also provides an opportunity for the clinician to decide, based on the parents' responses to the contract, whether she or he will continue with the intake process and take the child or teen on as a client. For example, if the parents refuse to agree to a teen ordinarily having a zone of privacy, a clinician may determine that she or he is not the appropriate provider and would refer the family and teen to another provider, rather than continuing the process of intake and treatment.*

If meeting with parents first is not feasible, or does not fit the intake procedure a clinician usually follows, a possible alternative would be to meet at the outset with parents and children or teens together, so as to engage in a discussion of the treatment parameters and other relevant topics before asking the parents and children or teens to sign the consent form and/or treatment contract.

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. I will ask you 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 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 am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving 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, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. 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 my 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 those 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 my 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 [may be] 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 psychologist 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 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 would keep this information confidential. If you child tells me that he/she is drinking and driving or is a

passenger in a car with a driver who is drunk, I would 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 would not keep that information confidential.

Example: If your child tells me that he/she is having voluntary, protected sex with a peer, I would 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 [this State] 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 your 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 $XXX per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Child/Adolescent Patient:

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor's Signature* _____ Date_____

Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my 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 my 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 _____ Date_____

Parent/Guardian Signature _____ Date_____

* For very young children, the child's signature is not necessary

Thanks to Sherry Kraft, Ph.D., clinical psychologist for The Center for Ethical Practice, for use of some the examples and concepts in the child/adolescent portion of this template informed consent.
http://www.centerforethicalpractice.org