COUNSELOR-CLIENT SERVICE AGREEMENT

Welcome to Pelorus Counseling and Consulting, LLC. 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 you as the client and Pelorus Counseling and Consulting, LLC with Tiffany Harvey, LPC, CCMHC, NCC as your therapist. We can discuss any questions you have before you sign any documents or at any time in the future.

MENTAL HEALTH 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. As your therapist, I have corresponding responsibilities to you. These rights and responsibilities are described in the sections that follow.

RISKS AND BENEFITS OF PSYCHOTHERAPY

Psychotherapy has both benefits and risks. Because the process of psychotherapy often requires discussing the unpleasant aspects of your life, you may experience uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Despite the potential risks, 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. However, there are no guarantees about results of therapy nor of experiences during the therapeutic process.

THERAPIST RESPONSIBILITIES

As a therapist, my utmost responsibility lies with helping you achieve your goals in treatment using ethical care and principles. My stance as a therapist lies in helping you find your way as you are on a path of healing. I will be assessing and evaluating you based on your presenting needs and making recommendations regarding treatment. I believe in a multilayered approach for treatment, and I will customize it based on your needs. This means that I may use a variety of interventions and will ask you to do things outside of sessions, such as reading, using a journal, watching videos or movies, etc., as well as in session discussions. I will also develop a treatment plan with you, where we will discuss your goals and interventions used to achieve them.

CLIENT RESPONSIBILITIES

You will get the most out of therapy through your participation. You are expected to attend therapy appointments regularly, complete suggested readings, journal, complete homework assignments, and otherwise use therapy to its fullest extent in order to achieve maximum results. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on the things we discuss outside of the sessions. You understand that regular compliance with attendance is part of a requirement for remaining in services with Pelorus Counseling and Consulting, LLC and lack of compliance is grounds for termination from services.

TREATMENT PLANNING

The first 2-4 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 doubt(s) persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion. You understand that I may recommend more time in treatment based on your presenting issues, and that I offer no guarantees of achieving goals within a given timeframe.

Please initial here to indicate you acknowledge and accept mental health services, risks, benefits, and each party's responsibilities, including treatment compliance: _____

TERMINATION

Services will be terminated when therapeutic goals are met and it is determined that you no longer need services as you have reached the level of functioning you desired. We will discuss this together and prepare for termination in advance with planning. You may discontinue services at any time through discussing this with me as well as providing me with something in writing. Services will be terminated with you immediately under the following conditions: nonpayment as agreed per fees schedule, or if at any point you or a person you are in a relationship with become a danger to me or a person I am in a relationship with. If you do not show to 1 appointment and/or cancel or frequently reschedule appointments or do not respond to my outreach efforts, your services will be terminated under those conditions as well. Please note that no weapons of any kind under any circumstances are permitted in the offices of Pelorus Counseling and Consulting, LLC.

Please initial here to indicate you acknowledge and understand termination policy: _____

PROFESSIONAL FEES

The standard fee for services is $100 per 45-minute therapy session billable through credit card processing in advance through automatic debit. A valid credit or debit card number must remain on file at all times. I do not allow for balances to accrue. Payments are made at the beginning of each session and if payments are not able to be made the session will be canceled and considered a "no show" and will be charged immediately via electronic debit on the day of the missed appointment. Nonpayment of fees will be grounds for termination of services as discussed in termination policy.

Please initial here to indicate you acknowledge and agree to the fee policy: _____

REQUESTS FOR LETTERS, FORMS, COURT

Please note that I do not participate with court evaluations or hearings, including custody, legal issues, etc., and require that you obtain outside evaluations as necessary if this is an issue to preserve the essence of the therapy relationship. I do not provide letter-writing or filling out forms as a standard part of my practice. If this is

something you desire, I will process this on a case-by-case basis and will require 30 days' advance notice. Please note that there will be a minimum charge of $25.00 for a letter if it is estimated to take 20 minutes of processing; every 15 minutes thereafter will be an additional $25.00. You will be provided with an estimation in advance of charges and must pay in advance for any letter writing if we decide together that this is something we will pursue.

Please initial here to indicate you acknowledge and agree to the letters, forms, and court fee policy:
_____

APPOINTMENTS AND CANCELLATION POLICY
Appointments will ordinarily be 60 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. Your appointment time is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 48 hours' notice. If you miss a session without canceling, or cancel with less than 48 hours' notice, my policy is to count this as a "no show" and you will be charged a no-show fee of $60. Your services will also be terminated. You are responsible for coming to your session on time; if you are late, your appointment will not be extended; it will still end at the same time it would have ended if you arrived on time. I do not excuse any absences or cancellations later than 48 hours' notice.

Please initial here to indicate you acknowledge and agree to the appointment and cancellation policy:
_____

INSURANCE

I accept insurance payments directly from some companies at this time and am a participating provider with several insurance panels at this time. If I am submitting insurance claims on your behalf, you agree to pay any co-pays, deductibles, or other payments as set forth and determined by your insurance company at the time of services and will not accrue a balance. You understand that if for some reason, claims are denied, you are responsible for unpaid fees. If I am not an "In-network" provider with an insurance carrier of your choice and you choose to submit your own claims, I am able to provide you with receipts of payment of services, which you are then able to submit to your insurance company for reimbursement. You will pay my full fee at the time of service of $100 regardless of what your insurance company reimburses. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to your insurance company, who can recommend a provider.

Please initial here to acknowledge your understanding of the insurance policy agreement and that you consent for me to release information to insurance companies on your behalf for necessary filing and submission of claims: _____

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained electronically through encrypted software that only I have access to. 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. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. 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.

Please initial here to acknowledge your understanding of the records policy: _____

CONFIDENTIALITY

The policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. You have been given the opportunity to ask questions regarding confidentiality and the limits of confidentiality and have those questions answered. Please remember that you may reopen the conversation at any time during our work together.

Please initial here to acknowledge your understanding of the confidentiality policy and that you have received a copy of the confidentiality policy: _____

CONTACTING ME

I am often not immediately available by telephone. 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 Rappahannock Area Community Services Board Emergency Services (540-373-6876), (2) go to your Local Hospital Emergency Room, or (3) call 911. I will make every attempt to inform you in advance of planned absences.

SOCIAL MEDIA POLICY

The policies about social media are fully described in a separate document entitled Social Media Practices. You have been provided with a copy of that document and we have discussed those issues and an opportunity to ask questions and have those questions answered. Please remember that you may reopen the conversation at any time during our work together.

Please initial here to acknowledge your understanding of the social media policy: _____

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk to 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, national origin, or source of payment. 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.

ATTORNEY FEES AND LITIGATION

If for some reason you are still unsatisfied with services with Pelorus Counseling and Consulting, LLC and you are unable to reach a resolution with me directly and chose to use litigation and settle the matter in court, you agree to and understand the following: In the event of litigation relating to the subject matter of this Agreement, the non-prevailing party shall reimburse the prevailing party for all reasonable attorney fees and costs resulting therefrom.

Please initial here to acknowledge your understanding of the attorney fee policy: _____

EMERGENCY TRANSFER

In the unlikely event that I become incapacitated through my death, illness, become missing, or am somehow otherwise unable to provide services to you, you acknowledge that confidentiality can be broken through the executor of my will and I will have services in place for you to be notified via a trusted colleague.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read and understand this Agreement and the Notice of Privacy Practices, maintained in a separated document and by signing this document you acknowledge and agree to their terms. You understand your rights and responsibilities in this agreement, have had an opportunity to ask any questions and have those questions answered and discuss them, and you are voluntarily consenting to psychotherapy.

Effective Date of Services and Contract (first appointment date): _____

_____
Printed Name of Client

_____ Date (today's date) _____

Signature of Client