

**Steffannie Roache MS LPC**  
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**COUNSELOR - CLIENT TREATMENT SERVICE AGREEMENT**

Welcome. 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. We can discuss any questions you have when you sign them or at any time in the future.

**THERAPY & 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 Counseling or Therapy, 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.

Therapy 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 therapy often requires discussing the unpleasant aspects of your life. However, therapy 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 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 doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

**APPOINTMENTS**

Appointments will ordinarily be 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 of your co-payment [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. 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**

You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check or cash; I am not able to process credit card charges as payment. Any checks returned to my office are subject to an additional fee of up to \$25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

- Intake session (90 minutes): \$135
- Individual session (50 minutes): \$90
- Couples/Families (50 minutes) / (90 minutes): \$110/\$135
- Group session (90 minutes): \$45/participant
- Phone calls longer than 5 minutes: Hourly rate (prorated)

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) 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, please disclose this information immediately, or in the future, as soon as you are aware of this. By signing this agreement, you indicate that you understand my role is not intended to gather information for the courts or to make judgments about you, your family, your employer(s), or any other parties. If I am compelled to be involved in any legal case, you will be expected to pay for the professional time required even if another party compels my participation.

## **INSURANCE**

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, my billing service and I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

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. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-IV or DSM-V. I can provide information on the DSM or allow you to review mine in order to learn more about diagnoses, if applicable.). Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by check or cash. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before the insurance

companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. 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 my provider contract.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. 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 a colleague.

### **PROFESSIONAL RECORDS**

I am required to keep appropriate records of the services that I provide. Your records are maintained in a secure location in the office. 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.

### **CONFIDENTIALITY**

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled [HIPPA Notice of Privacy Practices](#). You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation 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, when you sign this agreement form, it means it is understood that the client (child) and the parents are 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. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my voice mail, however do keep in mind that voice mail is not always "confidential"; 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 **Community Mental Health Services (503) 988-488** (I can provide these numbers for you and they are listed in the phone book), 2) 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 absence.

### **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, 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.

### **Agreement for Confidentiality of Individual Treatment**

I understand that it is Steffannie Roache's role is to provide therapeutic services so that I might feel better and/or improve my functioning. Steffannie Roache's role is not intended to gather information for the courts or to make judgments about me, my family, my employer, or any other parties.

Therefore, ***I agree that I will not call upon Steffannie Roache to provide treatment records or to testify in a future divorce, custody, workers compensation, or other legal actions.*** I understand that courts can appoint professionals who have had no prior contact with me or my family to conduct independent evaluations and make recommendations to the court.

I understand that it is Steffannie Roache's policy to have no court involvement in my case because that could harm our professional relationship and the ability to achieve my goals. My goals include resolving personal concerns so that I might have the greatest mental health and wellness, preserve my marriage and/or be a better parent, as appropriate. [In the case of family, couples or group counseling, it is my understanding that since I need to speak freely, I, my partner, and/or family is also agreeing never to ask Steffannie Roache to testify or have her records of my treatment in court.]

By signing this form I/we are both agreeing not to use any of my therapeutic intervention records or testimony in any future court proceedings.

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Signature of Patient or Personal Representative

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Signature of Patient or Personal Representative

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Printed Name of Patient or Personal Representative

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Printed Name of Patient or Personal Representative

Date \_\_\_\_\_ Description of Personal Representative's Authority: \_\_\_\_\_

### **CONSENT TO PSYCHOTHERAPY**

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

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Signature of Patient or Personal Representative

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Printed Name of Patient or Personal Representative

Date \_\_\_\_\_ Description of Personal Representative's Authority: \_\_\_\_\_